

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                              |                                                                                                                          |                                                                    |
|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                       |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    |
| {CZ824}<br>SS=C                                                                        | <p>408.811 FS; 59A-35.120 FAC Right of Inspection;<br/>Inspection Reports</p> <p>408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.-<br/>(1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application.</p> <p>(a) All inspections shall be unannounced, except as specified in s. 408.806.</p> <p>(b) Inspections for relicensure shall be conducted biennially unless otherwise specified by authorizing statutes or applicable rules.</p> <p>(2) Inspections conducted in conjunction with certification, comparable licensure requirements, or a recognized or approved accreditation organization may be accepted in lieu of a complete licensure inspection. However, a licensure inspection may also be conducted to review any licensure requirements that are not also requirements for certification.</p> <p>(3) The agency shall have access to and the licensee shall provide, or if requested send, copies of all provider records required during an inspection or other review at no cost to the agency, including records requested during an</p> |                                                                                | {CZ824}                                                                                      |                                                                                                                          |                                                                    |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**HOME SWEET HOME ASSISTED LIVING FACILITY CO**

**5700 SW 46 TERRACE  
MIAMI, FL 33155**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| {CZ824}                  | Continued From page 1<br><br>offsite review.<br>(4) A deficiency must be corrected within 30 calendar days after the provider is notified of inspection results unless an alternative timeframe is required or approved by the agency.<br>(5) The agency may require an applicant or licensee to submit a plan of correction for deficiencies. If required, the plan of correction must be filed with the agency within 10 calendar days after notification unless an alternative timeframe is required.<br>(6)(a) Each licensee shall maintain as public information, available upon request, records of all inspection reports pertaining to that provider that have been filed by the agency unless those reports are exempt from or contain information that is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution or is otherwise made confidential by law. Copies of such reports shall be retained in the records of the provider for at least 3 years following the date the reports are filed and issued, regardless of a change of ownership.<br>(b) A licensee shall, upon the request of any person who has completed a written application with intent to be admitted by such provider, any person who is a client of such provider, or any relative, spouse, or guardian of any such person, furnish to the requester a copy of the last inspection report pertaining to the licensed provider that was issued by the agency or by an accrediting organization if such report is used in lieu of a licensure inspection.<br><br>59A-35.120 Inspections.<br>(1) When regulatory violations are identified by the Agency:<br>(a) Deficiencies must be corrected within 30 days of the date the Agency sends the deficiency | {CZ824}             |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {CZ824}                                                                                | <p>Continued From page 2</p> <p>notice to the provider, unless an alternative timeframe is required or approved by the Agency.</p> <p>(b) The Agency may conduct an unannounced follow-up inspection or off-site review to verify correction of deficiencies at any time.</p> <p>(2) If an inspection is completed through off-site record review, any records requested by the Agency in conjunction with the review, must be received within 7 days of request and provided at no cost to the Agency. Each licensee shall maintain the records including medical and treatment records of a client and provide access to the Agency.</p> <p>(3) Providers that are exempt from Agency inspections due to accreditation oversight as prescribed in authorizing statutes must provide:</p> <p>(a) Documentation from the accrediting agency including the name of the accrediting agency, the beginning and expiration dates of the provider's accreditation, accreditation status and type must be submitted at the time of license application, or within 21 days of accreditation.</p> <p>(b) Documentation of each accreditation inspection including the accreditation organization's report of findings, the provider's response and the final determination must be submitted within 21 days of final determination or the provider is no longer exempt from Agency inspection.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure they have corrected multiple deficient practices within 30 days after being notified of them by the Agency for Health Care Administration (AHCA).</p> | {CZ824}                                                                        |                                                                                                                          |                          |                                                                    |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**HOME SWEET HOME ASSISTED LIVING FACILITY CO**

**5700 SW 46 TERRACE  
MIAMI, FL 33155**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| {CZ824}                  | <p>Continued From page 3</p> <p>Findings Included:</p> <p>A review of the facility's inspection history showed that the facility had not been in compliance with the following deficiencies: Right of Inspection, Licensure Requirements, Resident Care Supervision, Assistance with Self - Administration of Medication, Medication Records, Medication Storage and Disposal, Food Service - Dietary Standards, Facility Records, and Risk Management &amp; QA - Adverse Incident Reports.</p> <p>During an inspection on _____, it was found that the facility had still not reported any incident reports regarding previous _____, have not obtained a satisfactory fire and health inspection, and continued to not follow the proper procedures when assisting residents with assistance of self-administration of medication. Furthermore, the facility still does not maintain an accurate Medication Observation Record (MOR) and continued to leave medications unlocked. The facility also did not follow its menu and document the substitutions served during breakfast.</p> <p>On _____ at 10:14am, the Administrator stated "I was never told I had to submit it after it happened". At 10:15am, the Administrator understood and acknowledged the uncorrected deficiencies.</p> <p>Unclassified.</p> | {CZ824}             |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| (A 093)<br>SS=D                                                                        | <p>58A-5.020(2) FAC Food Service - Dietary Standards</p> <p>(2) DIETARY STANDARDS.</p> <p>(a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at:<br/><a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-04003">http://www.flrules.org/Gateway/reference.asp?No=Ref-04003</a>, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at:<br/><a href="http://iom.edu/Activities/Nutrition/SummaryDRIs/~media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf">http://iom.edu/Activities/Nutrition/SummaryDRIs/~media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf</a>. Therapeutic diets must meet these nutritional standards to the extent possible.</p> <p>(b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes.</p> <p>(c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and</p> | (A 093)                                                                        |                                                                                                                          |  |                                                                    |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {A 093}                                                                                | Continued From page 1<br><br>date reviewed. Portion sizes must be indicated on the menus or on a separate sheet.<br>1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.<br>2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.<br>(d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.<br>(e) Therapeutic diets must be prepared and served as ordered by the health care provider.<br>1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.<br>2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.<br>(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly | {A 093}                                                                        |                                                                                                                          |                          |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 093}                                                                                | <p>Continued From page 2</p> <p>distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of _____ the time between meals.</p> <p>(g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on _____.</p> <p>(h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has _____ with residents to serve, must be on _____ at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority</p> <p>This Statute or Rule _____ is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow its menu.</p> <p>Findings Included:</p> <p>On _____ at 7:53 am, observed Resident # 8 sitting in the dining area eating breakfast which consisted of a banana cut in pieces and two slices of toast with butter and cup of coffee with milk. At 8:15 am, observed Resident # 7 sitting in the dining area eating breakfast with consisted of two slice of toast with butter and a cup of coffee</p> | {A 093}                                                                        |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {A 093}                                                                                | Continued From page 3<br><br>with milk.<br><br>A review of the facility's menu for the month of _____ showed the scheduled breakfast was 4 oz. of assorted juices, ¾ cup of dry cereal or ½ cup of cooked cereal, 1 slice of bread, 1 teaspoon of margarine, and 8 oz of milk. There was no documentation of any substitutions documented on the facility's menu.<br><br>On _____ at 8:07 am, Staff B stated that she didn't offer the residents cooked cereal or dry cereal because "they don't eat it".<br><br>Class III<br>Uncorrected                                                                                                                                                                                                                   | {A 093}                                                                        |                                                                                                                          |                          |                                                                    |
| A 162<br>SS=D                                                                          | 58A-5.024(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name;<br>2. _____;<br>3. Race;<br>4. Date of birth;<br>5. Place of birth, if known;<br>6. Social security number;<br>7. Medicaid and/or Medicare number, or name of other health insurance _____;<br>8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and<br>9. Name, address, and telephone number of the health care provider and case manager, if applicable.<br>(b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule | A 162                                                                          |                                                                                                                          |                          |                                                                    |



Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| A 162                                                                                  | Continued From page 4<br><br>58A-5.0181, F.A.C.<br>(c) Any orders for medications, nursing services, therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.<br>(d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 58A-5.020, F.A.C., if applicable.<br>(e) The resident care record described in paragraph 58A-5.0182(1)(e), F.A.C.<br>(f) A _____ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their _____ recorded semi-annually.<br>(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract.<br>(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C.<br>(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C.<br>(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S.<br>(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly | A 162                                                                          |                                                                                                                          |                          |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |                                                                                                                          |                                                                    |
|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| A 162                                                                                  | Continued From page 5<br><br>written statement of funds or other property<br>disbursed as required in Section 429.27, F.S.<br>(l) If the resident is an _____ recipient, a copy of<br>the Department of Children and Families form<br>Alternate Care Certification for _____<br>_____, CF-ES 1006,<br>_____, which is hereby incorporated by reference<br>and available for review at:<br><a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-04004">http://www.flrules.org/Gateway/reference.asp?No=Ref-04004</a> . The absence of this form will not be<br>the basis for administrative action against a<br>facility if the facility can demonstrate that it has<br>made a good faith effort to obtain the required<br>documentation from the Department of Children<br>and Families.<br>(m) Documentation of the _____ of a<br>health care surrogate, health care proxy,<br>guardian, or the existence of a power of attorney,<br>where applicable.<br>(n) For hospice patients, the interdisciplinary care<br>plan and other documentation that the resident is<br>a hospice patient as required in Rule 58A-5.0181,<br>F.A.C.<br>(o) The resident's _____<br>DH Form 1896, if applicable.<br>(p) For independent living residents who receive<br>meals and occupy beds included within the<br>licensed capacity of an assisted living facility, but<br>who are not receiving any personal, limited<br>nursing, or extended congregate care services,<br>record keeping may be limited to the following at<br>the discretion of the facility:<br>1. A log listing the names of residents<br>participating in this arrangement;<br>2. The resident demographic data required in this<br>paragraph;<br>3. The health assessment described in Rule<br>58A-5.0181, F.A.C.;<br>4. The resident's contract described in Rule | A 162                                                                                        |                                                                                                                          |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| A 162                                                                                  | <p>Continued From page 6</p> <p>58A-5.025, F.A.C.; and</p> <p>5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.</p> <p>(q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.</p> <p>(r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to maintain documentation of the _____ of a health care surrogate, health care proxy, guardian or a Power of Attorney (POA) for one out of eight sampled residents (Resident # 6). Resident # 6 also did not have an updated resident contract after being admitted to the facility and Resident # 7 had an incomplete resident record and inaccurate health assessment.</p> <p>Findings included:</p> <p>A review of Resident # 6's records showed he was admitted to the facility on _____ and a signed 'Agreement for Day Care' signed by the resident's POA. Further review of Resident # 6's records showed a signed 'Informed Consent to Provide Assistance with Self-Administration of Medication by Unlicensed Personnel' and a 'Do</p> | A 162                                                                          |                                                                                                                          |                          |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| A 162                                                                                  | <p>Continued From page 7</p> <p>Not ..... &amp; Advance Directives Policy' dated ..... Resident # 6's progress notes and ..... log were also left blank. There was no legal documentation stating Resident # 6 had a legal POA nor was there a current resident contract on file.</p> <p>A review of Resident # 7's records showed he was admitted to the facility on ..... and revealed the full record consisted of a 'Resident's Demographic Information' sheet and a completed health assessment. Resident # 7's record revealed an unsigned 'Informed Consent to Provide Assistance with Self-Administration of Medication by Unlicensed Personnel' form along with an unsigned resident contract and no documentation of any progress notes since admission.</p> <p>On ..... at 8:15 am, observed Staff B assist Resident # 7 with self-administration of medication.</p> <p>A review of Resident # 7's health assessment showed it was completed on ..... and stated that Resident # 7 "needs medication administration".</p> <p>On ..... at 10:12 am, the Administrator stated "The contract is filled out, but not signed. His daughter hasn't come ..... to sign the contract". At 10:17 am, the Administrator also stated "No one here needs medication administration except for the resident who is ..... dependent".</p> <p>Class III</p> | A 162                                                                          |                                                                                                                          |                          |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 165}                                                                                | Continued From page 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | {A 165}                                                                                      |                                                                                                                          |  |                                                                    |
| {A 165}<br>SS=D                                                                        | <p>429.23(      &amp;      ) FS; 58A-5.0241 FAC Risk<br/>Mgmt &amp; QA; Adverse Incident Report</p> <p>429.23 Internal risk management and quality<br/>assurance program; adverse incidents and<br/>reporting requirements.-</p> <p>(1) Every facility licensed under this part may, as<br/>part of its administrative functions, voluntarily<br/>establish a risk management and quality<br/>assurance program, the purpose of which is to<br/>assess resident care practices, facility incident<br/>reports, deficiencies cited by the agency, adverse<br/>incident reports, and resident grievances and<br/>develop plans of action to correct and respond<br/>quickly to identify quality differences.</p> <p>(2) Every facility licensed under this part is<br/>required to maintain adverse incident reports. For<br/>purposes of this section, the term, "adverse<br/>incident" means:</p> <p>(a) An event over which facility personnel could<br/>exercise control rather than as a result of the<br/>resident's condition and results in:</p> <ol style="list-style-type: none"> <li>1.      ;</li> <li>2.      or      damage;</li> <li>3. Permanent      ;</li> <li>4.      or      of bones or joints;</li> <li>5. Any condition that required medical attention to<br/>which the resident has not given his or her<br/>consent, including failure to honor advanced<br/>directives;</li> <li>6. Any condition that requires the transfer of the<br/>resident from the facility to a unit providing more<br/>acute care due to the incident rather than the<br/>resident 's condition before the incident; or</li> <li>7. An event that is reported to law enforcement or<br/>its personnel for investigation; or</li> </ol> <p>(b) Resident elopement, if the elopement places<br/>the resident at risk of harm or injury.</p> <p>(3) Licensed facilities shall provide within 1</p> | {A 165}                                                                                      |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {A 165}                                                                                | Continued From page 9<br><br>business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.<br>(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.<br>(6) . . . , neglect, or . . . must be reported to the Department of Children and Families as required under chapter 415.<br>(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.<br>(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action | {A 165}                                                                        |                                                                                                                          |                          |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 165}                                                                                | <p>Continued From page 10</p> <p>by the appropriate board, the agency shall report this fact to such regulatory board.</p> <p>(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.</p> <p>(10) The Department of Elderly Affairs may adopt rules necessary to administer this section.</p> <p>58A-5.0241 Adverse Incident Report.</p> <p>(1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting.</p> <p>(2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility continued to fail to submit an adverse incident report within 15 days of an incident to the Agency for Healthcare Administration (AHCA) for two out of eight sampled residents (Resident # 1 and # 5). Both residents at the facility and were sent to the hospital with injuries for observation.</p> <p>Findings Included:</p> <p>A review of the online Adverse Incident Reporting system showed a report filed on in regards to Resident # 1's incident and was closed on</p> | {A 165}                                                                        |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                                                              |                                                                                                                          |                                                                    |
|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                       |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    |
| {A 165}                                                                                | Continued From page 11<br><br>Resident # 1 had at the facility.<br>The report stated 'The Agency administratively<br>closed the report because requested information<br>was not received from the provider'. Further<br>review of the report showed the Agency<br>requested additional information about the report<br>on at 3:51 pm, on at 4:13 pm, and<br>on at 9:18 am. There was no<br>documentation stating that the requested<br>information was provided to the Agency.<br><br>A second review of the online Adverse Incident<br>Reporting system showed no evidence of a report<br>filed for Resident # 5 after the resident had<br>and sustained an injury to the forehead and taken<br>to the hospital.<br><br>On at 10:14 am, the Administrator stated<br>"I was never told that I had to submit a report<br>after it happened and never knew I had to submit<br>extra information".<br><br>Class III<br>Uncorrected<br><br>AL243<br>SS=D 429.075(1) FS; 58A-5.0191(9) FAC LMH -<br>Training<br><br>429.075<br>(1) To obtain a limited mental health license, a<br>facility must hold a standard license as an<br>assisted living facility, must not have any current<br>uncorrected deficiencies or violations, and must<br>ensure that, within 6 months after receiving a<br>limited mental health license, the facility<br>administrator and the staff of the facility who are<br>in direct contact with mental health residents<br>must complete training of no less than 6 hours |                                                                                | {A 165}                                                                                      |                                                                                                                          |                                                                    |
|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | AL243                                                                                        |                                                                                                                          |                                                                    |



Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| AL243                                                                                  | <p>Continued From page 12</p> <p>related to their duties. Such designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training will be provided by or approved by the Department of Children and Families.</p> <p>58A-5.0191<br/>(9) LIMITED MENTAL HEALTH TRAINING.<br/>(a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training:</p> <p>1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses.</p> <p>a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility.</p> <p>b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule.</p> <p>2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics:</p> <p>a. Mental health diagnoses; and<br/>b. Mental health treatment such as:</p> <p>(i) Mental health needs, services, behaviors and</p> | AL243                                                                          |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| AL243                                                                                  | <p>Continued From page 13</p> <p>appropriate interventions;<br/>(II) Resident progress in achieving treatment goals;<br/>(III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and,<br/>( ) Crisis services and the _____ procedures.</p> <p>3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule.</p> <p>4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement.</p> <p>(b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on interview and record review, the facility failed to ensure two out of three sampled staff members received a minimum of 3 hours of continuing education (Staff B) and a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses (Staff C).</p> <p>Findings Included:</p> | AL243                                                                          |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| AL243                                                                                  | Continued From page 14<br><br>A review of Staff B's personnel records showed she was hired on /211 and the last Limited Mental Health (LMH) training was completed on . There was no documentation Staff B received an additional 3 hours of continuing education.<br><br>A review of Staff C's personnel records showed she was hired on . There was no documentation Staff C received a minimum of 6 hours of specialized training provided by the Department of Children and Families.<br><br>On at 9:55 am, the Administrator stated that she would have her staff retake the trainings.<br><br>Class III | AL243                                                                          |                                                                                                                          |                          |                                                                    |
| {A 000}                                                                                | Initial Comments<br><br>A revisit to a complaint investigation (complaint number 2019006856) was conducted at Home Sweet Home Assisted Living Facility Corp. on . Deficiencies were identified at the time of survey.                                                                                                                                                                                                                                                                                                                                                                                         | {A 000}                                                                        |                                                                                                                          |                          |                                                                    |
| {A 004}<br>SS=D                                                                        | 58A-5.016 FAC Licensure - Requirements<br><br>(1) SERVICE PROHIBITION. An assisted living facility may not represent that it provides any service other than a service for which it is licensed to provide.<br>(2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made without prior approval from the Agency Central                                                                                                                                                                            | {A 004}                                                                        |                                                                                                                          |                          |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {A 004}                                                                                | Continued From page 15<br><br>Office. Approval must be based on the compliance with the physical plant standards provided in Rule 58A-5.023, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in Rule 58A-5.0161, F.A.C.<br>(3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in Rule 58A-5.023, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection standards referenced in Rule 58A-5.0161, F.A.C.<br>(4) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter.<br>(5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 58A-5.0161, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to Part II, | {A 004}                                                                        |                                                                                                                          |                          |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                          |                                                                    |
|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| {A 004}                                                                                | <p>Continued From page 16</p> <p>Chapter 408, F.S., Section 429.14, F.S., and Rule Chapter 59A-35, F.A.C.</p> <p>(6) RESIDENTS RECEIVING STATE-FUNDED SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation, interview, and record review, the facility failed to have proof of an annual satisfactory health and fire inspection.</p> <p>Findings included:</p> <p>On at 7:30 am, observed a Miami - Dade Fire Rescue Department - Inspection Report and a State of Florida Department of Health County Health Department Group Care Inspection Report posted on the facility's bulletin board located next to the kitchen.</p> <p>A review of the Miami - Dade Fire Rescue Department - Inspection Report revealed that the last inspection was conducted on and the results were 'Inspected/N.O.V (Notice of Violations)'. The report also revealed a total of 11 violations and showed the facility must comply by</p> <p>A review of the State of Florida Department of Health County Health Department Group Care Inspection Report revealed the last inspection was conducted on . There was no documentation of a health inspection completed in 2019.</p> <p>On at 7:48 am, the Administrator stated</p> | {A 004}                                                                                      |                                                                                                                          |                                                                    |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**HOME SWEET HOME ASSISTED LIVING FACILITY CO**

**5700 SW 46 TERRACE  
MIAMI, FL 33155**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| {A 004}                  | Continued From page 17<br><br>that the health and fire departments hadn't done<br>their annual visits yet.<br><br>Class III<br>Uncorrected                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | {A 004}             |                                                                                                                          |                          |
| A 030<br>SS=D            | 58A-5.0182(6) FAC; 429.28( ) FS 429.27<br>Resident Care - Rights & Facility Procedures<br><br>58A-5.0182<br>(6) RESIDENT RIGHTS AND FACILITY<br>PROCEDURES.<br>(a) A copy of the Resident Bill of Rights as<br>described in section 429.28, F.S., or a summary<br>provided by the Long-Term Care Ombudsman<br>Program must be posted in full view in a freely<br>accessible resident area, and included in the<br>admission package provided pursuant to rule<br>58A-5.0181, F.A.C.<br>(b) In accordance with section 429.28, F.S., the<br>facility must have a written grievance procedure<br>for receiving and responding to resident<br>complaints and a written procedure to allow<br>residents to recommend changes to facility<br>policies and procedures. The facility must be able<br>to demonstrate that such procedure is<br>implemented upon receipt of a complaint.<br>(c) The telephone number for lodging complaints<br>against a facility or facility staff must be posted in<br>full view in a common area accessible to all<br>residents. The telephone numbers are: the<br>Long-Term Care Ombudsman Program,<br>1(888)831-0404; _____, Rights Florida,<br>1(800)342-0823; the Agency Consumer Hotline<br>1(888)419-3456, and the statewide toll-free<br>telephone number of the Florida _____ Hotline,<br>1(800)96- _____ or 1(800)962-2873. The<br>telephone numbers must be posted in close | A 030               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| A 030                                                                                  | Continued From page 18<br><br>proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.<br>(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 58A-5.0181, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:<br>1. Resident responsibilities;<br>2. _____ and tobacco use;<br>3. Medication storage;<br>4. Resident elopement;<br>5. Reporting resident _____, neglect, and _____;<br>6. Administrative and housekeeping schedules and requirements;<br>7. _____ control, sanitation, and universal precautions; and,<br>8. The requirements for coordinating the delivery of services to residents by third party providers.<br>(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.<br>(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. | A 030                                                                          |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| A 030                                                                                  | <p>Continued From page 19</p> <p>(g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . .</p> <p>429.28 Resident bill of rights.-</p> <p>(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:</p> <p>(a) Live in a safe and decent living environment, free from . . . . . and neglect.</p> <p>(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.</p> <p>(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.</p> <p>(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.</p> <p>(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence,</p> | A 030                                                                          |                                                                                                                          |  |                                                                    |



Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**HOME SWEET HOME ASSISTED LIVING FACILITY CO**

**5700 SW 46 TERRACE  
MIAMI, FL 33155**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 030                    | Continued From page 20<br><br>autonomy, and interaction within the community.<br>(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.<br>(g) Share a room with his or her spouse if both are residents of the facility.<br>(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.<br>(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.<br>(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making _____ for health care services, the provision of or arrangement of transportation to health care _____, and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.<br>(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally _____, the guardian shall be given at least 45 days' notice of a | A 030               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| A 030                                                                                  | Continued From page 21<br><br>nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.<br>(1) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without _____, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.<br>(2) The administrator of a facility shall ensure that a written notice of the rights, _____, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder _____ Hotline operated by the Department of Children and Families, and, if applicable, _____, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility | A 030                                                                          |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**HOME SWEET HOME ASSISTED LIVING FACILITY CO**

**5700 SW 46 TERRACE  
MIAMI, FL 33155**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 030                    | <p>Continued From page 22</p> <p>must ensure a resident 's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and . . . , Rights Florida.</p> <p>429.27(1)(a), FS<br/>Property and personal affairs of residents. -<br/>(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated or under state law, managing his or her own affairs.<br/>(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation and interview, the facility failed to respect one out of seven sampled residents' rights to be free of (Resident # 5). The resident was prevented from exiting bed by a sofa chair placed against it, which the resident could not remove without staff assistance.</p> <p>Findings Included:</p> | A 030               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**HOME SWEET HOME ASSISTED LIVING FACILITY CO**

**5700 SW 46 TERRACE  
MIAMI, FL 33155**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 030                    | Continued From page 23<br><br>On            at 7:25 am, observed a sofa chair<br>leaning against Resident # 5's bed, preventing<br>Resident # 5 to get out of bed.<br><br>On            at 7:25 am, Staff B stated that they<br>placed the chair against the bed because they<br>didn't want the resident to slip out of the bed.<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A 030               |                                                                                                                          |                          |
| (A 052)<br>SS=D          | 429.256(    ); 58A-5.0185 (3) Medication -<br>Assistance with Self-Admin<br><br>429.256<br>(3) Assistance with self-administration of<br>medication includes:<br>(a) Taking the medication, in its previously<br>dispensed, properly labeled container, including<br>an    syringe that is prefilled with the proper<br>dosage by a pharmacist and an    that is<br>prefilled by the manufacturer, from where it is<br>stored, and bringing it to the resident.<br>(b) In the presence of the resident, reading the<br>label, opening the container, removing a<br>prescribed amount of medication from the<br>container, and closing the container.<br>(c) Placing an oral dosage in the resident 's<br>or placing the dosage in another container and<br>helping the resident by lifting the container to his<br>or her   .<br>(d) Applying    medications.<br>(e) Returning the medication container to proper<br>storage.<br>(f) Keeping a record of when a resident receives<br>assistance with self-administration under this<br>section.<br>(g) Assisting with the use of a    , including | (A 052)             |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                                                              |                                                                                                                          |                                                                    |
|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                       |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| {A 052}                                                                                | <p>Continued From page 24</p> <p>removing the cap of a _____, opening the unit dose of _____ solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the _____.</p> <p>(h) Using a _____ to perform _____ level checks.</p> <p>(i) Assisting with putting on and taking off _____ stockings.</p> <p>(j) Assisting with applying and removing an _____ but not with titrating the prescribed _____ settings.</p> <p>(k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device.</p> <p>(l) Assisting with measuring vital signs.</p> <p>(m) Assisting with _____ bags.</p> <p>(4) Assistance with self-administration does not include:</p> <p>(a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.</p> <p>(b) The preparation of syringes for injection or the administration of medications by any injectable route.</p> <p>(c) Administration of medications by way of a tube inserted in a _____ of the body.</p> <p>(d) Administration of _____ preparations.</p> <p>(e) Irrigations or debriding agents used in the treatment of a skin condition.</p> <p>(f) _____ or _____ preparations.</p> <p>(g) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a</p> |                                                                                | {A 052}                                                                                      |                                                                                                                          |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 052}                                                                                | <p>Continued From page 25</p> <p>competent resident.</p> <p>(h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.</p> <p>58A-5.0185 (3)<br/>ASSISTANCE WITH SELF-ADMINISTRATION.<br/>(a) Any unlicensed person providing assistance with self-administration of medication must be 18 years of age or older, trained to assist with self-administered medication pursuant to the training requirements of rule 58A-5.0191, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule.</p> <p>(b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed.</p> <p>(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.</p> <p>(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.</p> <p>(e) When a resident who receives assistance with</p> | {A 052}                                                                        |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 052}                                                                                | <p>Continued From page 26</p> <p>medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:</p> <ol style="list-style-type: none"> <li>1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,</li> <li>2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,</li> <li>3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or</li> <li>4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.</li> </ol> <p>(f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S.</p> <ol style="list-style-type: none"> <li>1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.</li> <li>2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition.</li> </ol> <p>(g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation and record review, the facility failed to follow the procedures outlined by</p> | {A 052}                                                                        |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 052}                                                                                | <p>Continued From page 27</p> <p>the State when assisting three out of eight sampled residents with self-administration of medication (Resident # 4, # 7, and # 8).</p> <p>Findings Included:</p> <p>On _____ at 7:21 am, observed Resident # 8 sitting in the dining area eating breakfast. There was a clear plastic cup filled with approximately 8 medications next to her cup of coffee with milk.</p> <p>A review of Resident # 8's Medication Observation Record (MOR) showed the following medications were initiated as given by Staff B:</p> <p>_____, 5 mg, _____ Tab 650 mg, losartan Tab 150 mg, Levothyroxin Tab 100 mcg, _____ 10 mg, and _____ 10 mg.</p> <p>On _____ at 8 am, observed Staff B don gloves, grab Resident # 4's medications, locked the medication cabinet, and brought the medications to where Resident # 4 was sitting. Staff B stated Resident # 4's name and stated in Spanish "Here, your medications". Staff B then popped these medications out of their medication _____ pack onto a clear plastic cup: _____, and _____. Staff B then handed the cup to the resident and signed the MOR and returned to the medication cabinet to store the medications. Staff B never read the label of the medication to the resident or observed the resident take their medication before signing the MOR.</p> <p>On _____ at 8:15 am, observed Staff B don gloves, grab Resident # 7's medication from the medication cabinet, walked over to where Resident # 7 was sitting and stated out loud Resident # 7's name. Staff B then popped these</p> | {A 052}                                                                        |                                                                                                                          |  |                                                                    |



Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {A 052}                                                                                | Continued From page 28<br><br>medications out of their medication . . . . pack<br>onto a clear plastic cup; . . . . Loratidine,<br>. . . . , Reno Caps, and . . . . Staff B<br>then stated in Spanish "Here, your medications".<br>Staff B then signed the MOR before observing<br>the resident take their medication. Staff B never<br>read the label of the medication to the resident<br>and observe the resident take their medication<br>before signing the MOR.<br><br>On . . . . at 10:15 am, the Administrator stated<br>"[Staff B] was nervous while being watched doing<br>med pass. She's really good at it and does it<br>every day".<br><br>Class III<br>Uncorrected                                                                                                                                                                                                | {A 052}                                                                        |                                                                                                                          |                          |                                                                    |
| {A 054}<br>SS=D                                                                        | 58A-5.0185(5) FAC Medication - Records<br><br>(5) MEDICATION RECORDS.<br>(a) For residents who use a pill organizer<br>managed in subsection (2), the facility must keep<br>either the original labeled medication container;<br>or a medication listing with the prescription<br>number, the name and address of the issuing<br>pharmacy, the health care provider's name, the<br>resident's name, the date dispensed, the name<br>and strength of the drug, and the directions for<br>use.<br>(b) The facility must maintain a daily medication<br>observation record for each resident who<br>receives assistance with self-administration of<br>medications or medication administration. A<br>medication observation record must be<br>immediately updated each time the medication is<br>offered or administered and include:<br>1. The name of the resident and any known | {A 054}                                                                        |                                                                                                                          |                          |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 054}                                                                                | <p>Continued From page 29</p> <p>1. the resident may have;</p> <p>2. The name of the resident's health care provider and the health care provider's telephone number;</p> <p>3. The name, strength, and directions for use of each medication; and,</p> <p>4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.</p> <p>(c) For medications that serve as chemical restraints, the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation, interview and record review, the facility failed to immediately update the Medication Observation Records (MOR) each time the medication was offered when assisting one out of eight sampled residents (Resident # 8) with self-administration of medication. The facility also failed to maintain an accurate MOR for Resident # 7.</p> <p>Findings Included:</p> <p>1)<br/>A review of Resident # 8's Medication Observation Record (MOR) showed the following medications were initiated as given by Staff B:<br/>5mg, Tab 650<br/>mg, lorbesartan Tab 150 mg, Levothyroxin Tab 100 mcg, 10 mg, and<br/>10 mg.</p> <p>At 7:21 am, observed Resident # 8 sitting in the dining area eating breakfast and there was a clear plastic cup filled with approximately 8 medications next to her cup of coffee with milk.</p> | {A 054}                                                                        |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b> |                                                                                                                          |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| {A 054}                                                                                | Continued From page 30<br><br>2)<br><br>A review of Resident # 7's MOR shows a handwritten document from the pharmacy with the following medications: _____, Reno Caps, _____, Loratidine, and _____.<br><br>Resident # 7's name was also written on the top right corner of the handwritten MOR. There was no documentation on the name of the resident's health care provider and phone number, the strength and directions for use of each medication, any known _____, and a record of each time the medication is taken.<br><br>On _____ at 10:15 am, the Administrator stated "[Staff B] was nervous while being watched doing med pass. She's really good at it and does it every day" and acknowledge that the MORs have to be updated.<br><br>Class III<br>Uncorrected | {A 054}                                                                                      |                                                                                                                          |  |                                                                    |
| {A 055}<br>SS=D                                                                        | 58A-5.0185(6) FAC Medication - Storage and Disposal<br><br>(6) MEDICATION STORAGE AND DISPOSAL.<br>(a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out                                                                                                                                                                                                     | {A 055}                                                                                      |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {A 055}                                                                                | Continued From page 31<br><br>of sight of other residents.<br>(b) Both prescription and over-the-counter<br>medications for residents must be centrally stored<br>if:<br>1. The facility administers the medication;<br>2. The resident requests central storage. The<br>facility must maintain a list of all medications<br>being stored pursuant to such a request;<br>3. The medication is determined and documented<br>by the health care provider to be hazardous if<br>kept in the personal possession of the person for<br>whom it is prescribed;<br>4. The resident fails to maintain the medication in<br>a safe manner as described in this paragraph;<br>5. The facility determines that, because of<br>physical arrangements and the conditions or<br>habits of residents, the personal possession of<br>medication by a resident poses a safety hazard to<br>other residents, or<br>6. The facility's rules and regulations require<br>central storage of medication and that policy has<br>been provided to the resident before admission<br>as required in rule 58A-5.0181, F.A.C.<br>(c) Centrally stored medications must be:<br>1. Kept in a locked cabinet; locked cart; or other<br>locked storage receptacle, room, or area at all<br>times;<br>2. Located in an area free of dampness and<br>abnormal temperature, except that a medication<br>requiring refrigeration must be kept refrigerated.<br>Refrigerated medications must be secured by<br>being kept in a locked container within the<br>refrigerator, by keeping the refrigerator locked, or<br>by keeping the area in which the refrigerator is<br>located locked;<br>3. Accessible to staff responsible for filling<br>pill-organizers, assisting with self-administration<br>of medication, or administering medication. Such<br>staff must have ready access to keys or codes to | {A 055}                                                                        |                                                                                                                          |                          |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| {A 055}                                                                                | <p>Continued From page 32</p> <p>the medication storage areas at all times; and,</p> <p>4. Kept separately from the medications of other residents and properly closed or sealed.</p> <p>(d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider.</p> <p>(e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may be disposed of in accordance with paragraph (f).</p> <p>(f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.</p> <p>(g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation and interview, the facility failed to keep medications locked at all times.</p> | {A 055}                                                                        |                                                                                                                          |                          |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                              |                                                                                                                          |                                                                    |
|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                       |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                    |
| {A 055}                                                                                | Continued From page 33<br><br>Findings Included:<br><br>On _____ at 7:20am, observed the medication cabinet open and unlocked. Staff B stated, "this is where we have our medications". At 8:09am, observed the medication cabinet unlocked a second time. Staff B unlocked it and left the cabinet unattended while she prepared breakfast.<br><br>On _____ at 10:15am, the Administrator stated that she would talk to her staff about the unlocked medication cabinet.<br><br>Class III<br>Uncorrected                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | {A 055}                                                                                      |                                                                                                                          |                                                                    |
| A 058<br>SS=D                                                                          | 429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies<br><br>429.42 Pharmacy and dietary services.-<br>(1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required.<br>(2) A corrective action plan for deficiencies |                                                                                | A 058                                                                                        |                                                                                                                          |                                                                    |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**HOME SWEET HOME ASSISTED LIVING FACILITY CO**

**5700 SW 46 TERRACE  
MIAMI, FL 33155**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 058                    | <p>Continued From page 34</p> <p>related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening.</p> <p>58A-5.033(3)<br/>(3) EMPLOYMENT OF A CONSULTANT.<br/>(a) Medication Deficiencies.<br/>1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency.<br/>2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit.<br/>3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such</p> | A 058               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| A 058                                                                                  | <p>Continued From page 35</p> <p>consultant services are no longer required. The agency must provide the facility with written notification of such determination.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation, interview and record review, the facility failed to correct three class III deficiencies regarding medications. the facility is required to employ a licensed registered nurse or licensed pharmacist to provide at least quarterly onsite consultation until the inspection team from the agency determines that such consultation services are no longer required. The facility is also required to develop a corrective action plan for deficiencies related to medication within 48 hours after notification of this deficiency.</p> <p>Findings:</p> <p>On , a review of the facility's inspection report showed that it was cited for deficient practices regarding assistance with self-administration of medication, medication records, and medication storage and disposal.</p> <p>On between 7:14 am and 10:24 am, observations and record review revealed continued deficient practices regarding assistance with self-administration of medication, medication records, and medication storage and disposal.</p> <p>Class III</p> | A 058                                                                          |                                                                                                                          |                          |                                                                    |



Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**HOME SWEET HOME ASSISTED LIVING FACILITY CO**

**5700 SW 46 TERRACE  
MIAMI, FL 33155**

| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |     |  |     |        |     |       |     |       |     |       |     |        |     |       |     |       |     |       |     |       |  |  |
|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-----|--|-----|--------|-----|-------|-----|-------|-----|-------|-----|--------|-----|-------|-----|-------|-----|-------|-----|-------|--|--|
| A 079                                                                  | Continued From page 36                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | A 079                                                                  |                                                                                                                          |                          |     |  |     |        |     |       |     |       |     |       |     |        |     |       |     |       |     |       |     |       |  |  |
| A 079<br>SS=D                                                          | <p>58A-5.019(3) FAC Staffing Standards - Levels</p> <p>(3) STAFFING STANDARDS.</p> <p>(a) Minimum staffing:</p> <p>1. Facilities must maintain the following minimum staff hours per week:</p> <table border="1"> <thead> <tr> <th>Number of Residents, Day Care Participants, and Respite Care Residents</th> <th>Staff Hours/Week</th> </tr> </thead> <tbody> <tr> <td>0-5</td> <td>168</td> </tr> <tr> <td></td> <td>212</td> </tr> <tr> <td>16- 25</td> <td>253</td> </tr> <tr> <td>26-35</td> <td>294</td> </tr> <tr> <td>36-45</td> <td>335</td> </tr> <tr> <td>46-55</td> <td>375</td> </tr> <tr> <td>56- 65</td> <td>416</td> </tr> <tr> <td>66-75</td> <td>457</td> </tr> <tr> <td>76-85</td> <td>498</td> </tr> <tr> <td>86-95</td> <td>539</td> </tr> </tbody> </table> <p>For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.</p> <p>2. Independent living residents, as referenced in subsection 58A-5.024(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.</p> <p>3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.</p> <p>4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.</p> | Number of Residents, Day Care Participants, and Respite Care Residents | Staff Hours/Week                                                                                                         | 0-5                      | 168 |  | 212 | 16- 25 | 253 | 26-35 | 294 | 36-45 | 335 | 46-55 | 375 | 56- 65 | 416 | 66-75 | 457 | 76-85 | 498 | 86-95 | 539 | A 079 |  |  |
| Number of Residents, Day Care Participants, and Respite Care Residents | Staff Hours/Week                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        |                                                                                                                          |                          |     |  |     |        |     |       |     |       |     |       |     |        |     |       |     |       |     |       |     |       |  |  |
| 0-5                                                                    | 168                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |                          |     |  |     |        |     |       |     |       |     |       |     |        |     |       |     |       |     |       |     |       |  |  |
|                                                                        | 212                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |                          |     |  |     |        |     |       |     |       |     |       |     |        |     |       |     |       |     |       |     |       |  |  |
| 16- 25                                                                 | 253                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |                          |     |  |     |        |     |       |     |       |     |       |     |        |     |       |     |       |     |       |     |       |  |  |
| 26-35                                                                  | 294                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |                          |     |  |     |        |     |       |     |       |     |       |     |        |     |       |     |       |     |       |     |       |  |  |
| 36-45                                                                  | 335                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |                          |     |  |     |        |     |       |     |       |     |       |     |        |     |       |     |       |     |       |     |       |  |  |
| 46-55                                                                  | 375                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |                          |     |  |     |        |     |       |     |       |     |       |     |        |     |       |     |       |     |       |     |       |  |  |
| 56- 65                                                                 | 416                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |                          |     |  |     |        |     |       |     |       |     |       |     |        |     |       |     |       |     |       |     |       |  |  |
| 66-75                                                                  | 457                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |                          |     |  |     |        |     |       |     |       |     |       |     |        |     |       |     |       |     |       |     |       |  |  |
| 76-85                                                                  | 498                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |                          |     |  |     |        |     |       |     |       |     |       |     |        |     |       |     |       |     |       |     |       |  |  |
| 86-95                                                                  | 539                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                                                                                                                          |                          |     |  |     |        |     |       |     |       |     |       |     |        |     |       |     |       |     |       |     |       |  |  |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**HOME SWEET HOME ASSISTED LIVING FACILITY CO**

**5700 SW 46 TERRACE  
MIAMI, FL 33155**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 079                    | Continued From page 37<br><br>5. A staff member who has completed courses in First Aid and ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times.<br>a. Documentation of attendance at First Aid or courses pursuant to subsection 58A-5.0191(5), F.A.C., satisfies this requirement.<br>b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and .<br>6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager.<br>7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement.<br>8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule.<br>9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. | A 079               |                                                                                                                          |                          |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| A 079                                                                                  | <p>Continued From page 38</p> <p>(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 58A-5.0182, F.A.C.</p> <p>(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.</p> <p>(d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met.</p> <p>1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time</p> | A 079                                                                          |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |                          |                                                              |
|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R<br/>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE<br/>MIAMI, FL 33155</b>                                   |                          |                                                              |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                              |
| A 079                                                                                  | <p>Continued From page 39</p> <p>specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs.</p> <p>2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency.</p> <p>(e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.</p> <p>(f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 58A-5.029, 58A-5.030 or 58A-5.031, F.A.C., respectively.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation, interview, and record review, the facility failed to maintain a written work schedule that reflected its 24-hour staffing pattern.</p> <p>Findings Included:</p> <p>On ....., observed a staffing calendar posted on the facility's bulletin board near the kitchen. A review of the facility's posted staffing schedule revealed that it was for the month of .....</p> <p>There was no documentation of a staffing schedule for the month of .....</p> <p>On ..... at 7:48am, the Administrator stated</p> | A 079                                                                          |                                                                                                                          |                          |                                                              |

Agency for Health Care Administration

|                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |  |                                                                    |
|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HOME SWEET HOME ASSISTED LIVING FACILITY CO</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5700 SW 46 TERRACE</b><br><b>MIAMI, FL 33155</b>                             |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| A 079                                                                                  | Continued From page 40<br><br>"My consultant hasn't passed by yet to give me<br>the updated paperwork for the month".<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A 079                                                                          |                                                                                                                          |  |                                                                    |
| A 085<br>SS=D                                                                          | 58A-5.0191(7) FAC Training - Nutrition & Food<br>Service<br><br>(7) NUTRITION AND FOOD SERVICE. The<br>administrator or person designated by the<br>administrator as responsible for the facility's food<br>service and the day-to-day supervision of food<br>service staff must obtain, annually, a minimum of<br>2 hours continuing education in topics pertinent to<br>nutrition and food service in an assisted living<br>facility. This requirement does not apply to<br>administrators and designees who are exempt<br>from training requirements under paragraph<br>58A-5.020(1)(b). A certified food manager,<br>licensed dietician, registered dietary technician or<br>health department sanitarian is qualified to train<br>assisted living facility staff in nutrition and food<br>service.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview, and record<br>review, the facility failed to ensure that Staff<br>responsible for the facility's food service and the<br>day-to-day supervision of food service staff<br>obtain, annually, a minimum of 2 hours continuing<br>education in topics pertinent to nutrition and food<br>service in an assisted living facility for two out of<br>three sampled staff members (Staff B and C).<br><br>Findings Included:<br><br>On at 8:06am, observed Staff B in the<br>kitchen preparing breakfast for Resident # 7. At | A 085                                                                          |                                                                                                                          |  |                                                                    |

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967505</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/02/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**HOME SWEET HOME ASSISTED LIVING FACILITY CO**

**5700 SW 46 TERRACE  
MIAMI, FL 33155**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 085                    | <p>Continued From page 41</p> <p>8:53am, Staff C stated "I cook sometimes on the weekends, but [Staff B] usually cooks on the weekdays".</p> <p>A review of Staff B's personnel records showed a certificate of completing for 2 hours of Nutrition and Food Service including 1 hour of Safe Food Handling dated _____ - 2019. There was no documentation that showed Staff B received continuing education regarding nutrition and food service in 2019.</p> <p>On _____ at 9:12am, an interview with the licensed dietician that provides the training revealed that Staff C never completed the training and the facility only renewed the menu, but not the trainings.</p> <p>Class III</p> | A 085               |                                                                                                                          |                          |