STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966724	11/19/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
My Sweet Home Ii	214 Nw 120 Avenue Miami, FL 33182	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced limited nursing services monitoring survey was conducted on . My Sweet Home Ii had deficiencies at the time of the survey.

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

Based on observation, record review and interview the Assisted Living Facility failed to obtain a written order from 1 out of 2 sampled resident's physician for the use of half-bed rail as well as resident's consent for the use of half-bed rail.

Findings include:

Observation during tour of the facility on at 10 a.m. revealed that resident #1 was lying on her bed on # with half-bed rail raised.

Record review of resident #1's file revealed that there was not written order of resident #1's physician for the use of half-bed rail as well as resident's consent for the use of half-bed rail.

Administrator acknowledged findings on at 12 p.m.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on observation, interview and record review the Assisted Living Facility failed to obtain a doctor order for the use of for one out of two sampled residents (#2).

Findings include:

Observed during tour on at 10 a.m. that resident #2 was lying on her bed on # with concentrator next to resident #2.

Caregiver_A on at 10 a.m. stated that concentrator next to resident #2 belongs to resident #2.

Record review for resident #2's file revealed that there was no doctor order that indicates that resident #2 needs either that resident #2 is able to self- administer

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
My Sweet Home II
214 Nw 120 Avenue
Miami, FL 33182

Dear Administrator:

This letter reports the findings of a state Limited Nursing Services (LNS) Monitoring survey that was conducted on , 2013 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe.

Staff from this office will conduct a review after 1/25/2014 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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

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

Sincerely,

Kristal Branton for

Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone (305) 593-3100; Fax (305) 593-3121