

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 03/03/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11967507	(X3) DATE SURVEY COMPLETED 02/10/2014
NAME OF PROVIDER OR SUPPLIER Belen Sweet Home Alf li Inc	STREET ADDRESS, CITY, STATE, ZIP CODE 11825 Sw 206 Street Miami, FL 33177	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced limited nursing services monitoring survey was conducted on . Belen Sweet Home Alf li Inc 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 doctor order for the use of half-bed rail as well as resident's consent to use half-bed rail prior to use for 1 out of 1 sampled residents (#1).

Findings include:

1. Observation on at 1:10 p.m. revealed that on :# resident #1's bed had a half-bed attached to his/her bed.
2. Record review for resident #1's file revealed that there was not written doctor order for the use of half-bed rail either consent to use half-bed rail
3. In an interview with caregiver_A on at 1:15 p.m. revealed that resident #1 used half-bed rail up while on bed.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Belen Sweet Home Alf li Inc
11825 Sw 206 Street
Miami, FL 33177

Dear Administrator:

This letter reports the findings of a state Limited Nursing Services (LNS) Monitoring survey that was conducted on , 2014 by representative(s) of this office.

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

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

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

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

Sincerely,

(305) 593-3100
Field Office Manager

AMD:sy
Enclosure
XG90

