

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 04/14/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11967429	(X3) DATE SURVEY COMPLETED 04/01/2015
NAME OF PROVIDER OR SUPPLIER SWEET HOPE ASSISTED LIVING CORP	STREET ADDRESS, CITY, STATE, ZIP CODE 13551 S W 208 STREET MIAMI, FL 33177	

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

0000 - Initial Comments

A Limited Nursing Services Monitoring survey was conducted on _____, 2015. Sweet Hope Assisted Living Corp with Limited Nursing Services component had the following deficiency at time of the survey:

N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on record review and interview, the Assisted Living Facility failed to employ or contract a registered nurse (RN) to supervise the licensed practical nurse (LPN) who was contracted to provide limited nursing services (LNS) as needed to the residents.

Finding included:

Record review revealed the facility contracted a LPN to provide limited nursing services to residents as needed. The facility failed to have a contracted or employed RN to supervise the LPN contracted to provide LNS.

In an interview with the Caregiver on _____ / _____ at 9:38 AM revealed that facility's Administrator thought that it was enough to have LPN.

Class III



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Sweet Hope Assisted Living Corp
13551 S W 208 Street
Miami, FL 33177

Dear Administrator:

This letter reports the findings of a Limited Nursing Services Monitoring survey that was conducted on , 2015 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

XG90

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