STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964442	05/19/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
A SWEET ALF, INC	18400 NW 81 COURT HIALEAH, FL 33015	

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. A Sweet ALF, Inc. with Limited Mental Health and Limited Nursing Services components had a deficiency at time of survey.

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

Based on record review and interview facility failed to conduct a face to face medical examination by a health care provider as part of the continued residency criteria after a significant change for 1 out of 2 sampled residents (# 1).

Findings included:

Record review of resident # 1 revealed that resident is receiving hospice services since with a diagnosis of . Record review of last health assessment (1823) that was completed on stated that resident was independent with eating, required supervision with and toileting and assistance with the rest of her activities of daily living.

On at 8:50 am caregiver stated that resident is independent with eating and requires total assistance with the rest of her activities of daily living.

During exit conference on at 9:20 am facility administrator stated on the phone that the doctor is coming to the facility today and that she will ask him for a new health assessment.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

16, 2015

Administrator
A Sweet Alf, Inc
18400 Nw 81 Court
Hialeah, FL 33015

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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Kristal Branton

Arlene Mayo-Davis, RN
Field Office Manager

AMD:kb
Enclosure
XG90

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