STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943057	R
NAME OF PROVIDER OR SUPPLIER **MY SWEET HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **11312 SW 203 TERRACE** **MIAMI, FL 33189**	

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

0000 Initial Comments

An Extended Congregate Care (ECC) Monitoring survey revisit was conducted on / and concluded on / / . My Sweet Home had deficiencies identified at the time of the survey.

0160 Records - Facility

Based on observation, record review, and interview the facility Still failed to have an up to date admission and discharge log with one out of eight (Resident #8) sampled residents.

Findings include:

Interview on / at 10:00 AM, Resident #8's sister stated "My brother is a facility resident. We visit him frequently."

Observation on / / at 6:30 AM showed Resident #8 sleeping in a , he shared with Resident #3.

Interview on / at 11:00 AM, the facility caregiver stated "His family did not pick him up yesterday."

Record review revealed that the facility's admission and discharge log did not have Resident #8 documented.

Uncorrected Class III

E210 ECC - Training

Based on record review and interview, the facility Still failed to provide proof of Extended Congregate Care (ECC) in-service training for two out of four sampled staff (Staff B and C) within 6 months of employment.

Findings include:

Review of Staff B and C's records on / at 1:00 PM showed it did not contain documentation that the staff members received in-service training regarding ECC within 6 months of employment. Staff B was hired on and Staff C was hired on .

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NAME OF PROVIDER OR SUPPLIER **MY SWEET HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **11312 SW 203 TERRACE** **MIAMI, FL 33189**	

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

Interview conducted on at 2:30 PM, the facility's Administrator stated that Staff B and C did not receive 2 hours of in-service training regarding ECC.

Uncorrected Class III

Z827 Unlicensed Activitv

Based on observations and interview, the facility Still failed to obtain a license prior to providing care and services to a census of seven (7) residents.

Findings include:

Interview on at 10:00 AM, Resident #8's sister stated "My brother is a facility resident. We visit him frequently."

Observation on at 6:30 AM showed Resident #8 sleeping in a he shared with Resident #3.

Interview on at 11:00 AM, the facility caregiver stated "His family did not pick him up yesterday."

Uncorrected unclassified deficiency.

State Form: Revisit Report

(Y1) **Provider / Supplier / CLIA / Identification Number**
AL11943057

(Y2) **Multiple Construction**
A. Building
B. Wing

(Y3) **Date of Revisit**
6/16/2015

Name of Facility
MY SWEET HOME

Street Address, City, State, Zip Code
11312 SW 203 TERRACE
MIAMI, FL 33189

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **A0078** Reg. # **58A-5.019(2) FAC** LSC	Correction Completed	ID Prefix **A0083** Reg. # **58A-5.0191(4) FAC** LSC	Correction Completed	ID Prefix **A0084** Reg. # **58A-5.0191(5) FAC** LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency — **Reviewed By** [signature] — **Date:** 7/20/15 — **Signature of Surveyor:** — **Date:**

Reviewed By CMS RO — **Reviewed By** — **Date:** — **Signature of Surveyor:** — **Date:**

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
My Sweet Home
11312 Sw 203 Terrace
Miami, FL 33189

Dear Administrator:

This letter reports the findings of an Extended Congregate Care Monitoring survey conducted on , 2015by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

All deficiencies shall be corrected no later than 19, 2015.

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
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