STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966557	R
NAME OF PROVIDER OR SUPPLIER **SWEET CARE HOME ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **18260 SW 153 COURT** **MIAMI, FL 33187**	

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

0000 Initial Comments

A Standard Biennial revisit survey was conducted on . Sweet Care Home ALF, Inc. with Limited Mental Health and Limited Nursing Services components had the following deficiencies found at time of survey:

0032 Resident Care - Elopement Standards

Based on record review and interview the facility STILL failed to conduct two elopement drills yearly.

Findings as follow:

Record review showed the facility failed to perform two elopement drills yearly.

Phone interview on at 11:30 a.m. the facility's Administrator stated the facility had not performed any elopement drills.

Uncorrected Class III

0078 Staffing Standards - Staff

Based on record review and interview the facility STILL failed to have a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable for 1 out of 4 (Staff B) facility staff within 30 days of employment. The facility failed to have negative examinations documented on an annual basis for 1 out of 4 (Staff D) facility staff.

Findings as follow:

Record review found the facility didn't have a written statement from a health care provider documenting that Staff B did not have any signs or symptoms of communicable for Staff B (hire dated / /). Record review found Staff D's last freedom from communicable statement was dated . The facility did not have documentation of a negative examinations documented on an annual basis for Staff D.

Phone interview on at 11:30 a.m. the facility's Administrator stated they had the documentation but it was not in facility.

Uncorrected Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966557	R
NAME OF PROVIDER OR SUPPLIER **SWEET CARE HOME ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **18260 SW 153 COURT** **MIAMI, FL 33187**	

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

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on record review and interview the facility STILL failed to have 4 out of 4 (Staff A, B, C, D) facility staff trained in assisting residents with self administration of medications on annual basis.

Findings as follow:

Record review documented the last continuing education training received by staff were:
Staff A on
Staff B on
Staff C on
Staff D on

Phone interview on at 11:30 a.m. the facility's Administrator stated Staff A, B, C, and D assist with self administration of medication and had all their training documentation but it was not in facility.

Uncorrected Class III

0085 Training - Nutrition & Food Service

Based on record review and interview the facility STILL failed to have 4 out of 4 (Staff A, B, C, and D) facility staff trained in nutrition and food service on annual basis.

Findings as follow:

Record review found the facility had no documentation that Staff A, B, C, and D received nutrition and food service training. Staff A's last training was dated , Staff B received CORE training on , Staff C's last training was dated , and Staff D's last training was dated

Phone interview on at 11:30 a.m. the facility's Administrator acknowledged the findings and added he had all the training documentation but it was not in facility,

Uncorrected Class III

L243 LMH - Training

Based on record review and interview the facility STILL failed to have 3 out of 4 (Staff B, C, and D)

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966557	R
NAME OF PROVIDER OR SUPPLIER **SWEET CARE HOME ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **18260 SW 153 COURT** **MIAMI, FL 33187**	

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

trained in working with Limited Mental Health (LMH) residents and failed to have 1 out of 4 (Staff A) facility staff trained in 3 hours LMH continuing education training.

Findings as follow:

Record review showed the facility held an standard license with a LMH component.

Record review showed the facility had no documentation of Staff B, C, and D receiving Limited Mental Health training within 6 months of employment. Staff B hired , Staff C hired on , and Staff D hired . Staff A last continuing education training was dated / , there was not documentation that the staff member received 3 hours of continuing education training every two years.

Phone interview on at 11:30 a.m. the facility's Administrator acknowledged the findings that training documentation was not at the facility.

Uncorrected Class III

AH Form Approved

State Form: Revisit Report

(Y1) **Provider / Supplier / CLIA / Identification Number**
AL11966557

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

(Y3) **Date of Revisit**
9/

Name of Facility
SWEET CARE HOME ALF, INC

Street Address, City, State, Zip Code
18260 SW 153 COURT
MIAMI, FL 33187

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **A0160** Reg. # **58A-5.024(1) FAC** LSC		ID Prefix **AL241** Reg. # **58A-5.029(2) FAC** LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** [signature]	**Date:** 9/16/15	**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

Administrator
Sweet Care Home Alf, Inc
18260 Sw 153 Court
Miami, FL 33187

Dear Administrator:

This letter reports the findings of a Standard Biennial revisit survey conducted on 2015 by 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.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than** _____.

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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