STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967035	R
NAME OF PROVIDER OR SUPPLIER **SWEET ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **15942 SW 61 LANE** **MIAMI, FL 33193**	

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

0000 Initial Comments

A Complaint (CCR 2015012868) Revisit Survey was conducted on 03/02/16. Sweet ALF, Inc had the following deficiencies at the time of the survey:

0055 Medication - Storage and Disposal

Based on observations and interview the facility failed to keep medications locked up at all times for three out of seven (#1, #2, and #3) samples residents.
Findings included:
During the facility tour on / at 9:00 AM, observed in # over the counter medications (OTC) unlocked: , , 2 bottle of C 250 mg, E 100 mg, 500 mg, , milk of magnesia ( ). # was shared by Resident #3 and Resident #2. Furthermore inside of the facility's refrigerator found unlocked medications for Resident #1, Magestrol oral suspension USP 40 mg, and Resident #2's 50 mg.
During an interview on at 10:43 AM, Resident #3 stated "this is my ."
During an interview on the facility's Administrator acknowledged that medications were unlocked in the refrigerator and resident #.
Class III

0056 Medication - Labeling and Orders

Based on observations and interview the facility failed to have over the counter (OTC) medications properly labeled for one out of seven (#3) samples residents.
Findings included:
During the facility tour on / at 9:00 AM, observed in # OTC medications without the resident's name on them, , , 2 bottle of C 250 mg, E 100 mg, 500 mg, , milk of magnesia ( ).
During an interview on at 10:43 AM, Resident #3 stated "this is my ."
During an interview on the facility's Administrator acknowledged that OTC medications did not have resident's name the bottles.
Class III

Z814 Background Screening Clearinghouse

Based on record review and interview the facility failed to register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967035	R
NAME OF PROVIDER OR SUPPLIER **SWEET ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **15942 SW 61 LANE** **MIAMI, FL 33193**	

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

Finding included:

Record review on showed that the facility did have Staff A (administrator) hire on , Staff B (manager) hired on / , Staff C (caregiver) hired on , Staff D (caregiver) hire on registered with the agency's clearinghouse.

On reviewed the background screening website and it showed that facility staff were not registered.

During an interview on the facility's Administrator acknowledged the deficiencies found. She stated I did not know that I need to register staff with the clearinghouse.

Unclassified deficiency

Z828 Administrative Fines: Violations

Based on observations and interviews the facility exceeded its licensed capacity of six beds. The facility had a census of seven residents that were receiving housing, meals, and assistance with activities of daily living (ADLs).
Findings included:
Observation on at 9:00 AM during the facility tour with Staff D (caregiver) showed # had two single beds (one and another one hospital bed). At the facility's sliding door to the patio there was a person sitting in a wheelchair wearing pajamas and socks, Per Staff D he was identified a day care participant.
During an interview on at 9:10 AM Resident #4 stated "I sleep in that ", he pointed to glass window. "I have a ." He stated he slept on the bed to the left side in # . He stated the other person slept on the other bed, "hospital bed." He stated my have breakfast, lunch, and dinner here; he does not go home.
During an interview on at 10:30 AM Resident #6 stated "I'm living here for few months." He stated the resident sitting in a in front of sliding door in a wheelchair lives here in this house. He stated he have breakfast, lunch, and dinner. He stated staff assisted all of us with medications. He stated sometimes I like to sit in the black recliner that you see there near him. He stated "I cannot talk to him because he cannot have a conversation."
During an interview on / at 10:43 AM Resident #1 stated two residents live in next . He stated the person in a wheelchair lives here in this house. He stated he does not go home.
Unclassified Deficiency

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11967035 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEET HEART ALF, INC	15942 SW 61 LANE MIAMI, FL 33193

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0077	Correction	ID Prefix A0078	Correction	ID Prefix A0084	Correction
Reg. # 429.176 FS; 58A-5.019(1) FAC	Completed	Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.0191(5) FAC	Completed
LSC		LSC		LSC	
ID Prefix AL243	Correction	ID Prefix AZ815	Correction	ID Prefix	Correction
Reg. # 429.075(1) FS; 58A-5.0191(8) FAC	Completed	Reg. # 408.809, 435.02(2), 435.06	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE 3/16/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/13/2016	☐ YES ☐ NO

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Sweet Alf, Inc
15942 Sw 61 Lane
Miami, FL 33193

Dear Administrator:

This letter reports the findings of a complaint revisit survey conducted on , 2016 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 , 2016.**

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
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida