STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967243	03/29/2016
NAME OF PROVIDER OR SUPPLIER **HOME SWEET HOME ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **6981 COOLIDGE STREET HOLLYWOOD, FL 33024**	

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

0000 Initial Comments

A biennial relicensure survey was conducted in conjunction with an extended congregate care monitoring visit at Home Sweet Home Assisted Living on . Home Sweet Home Assisted Living had a deficiency at the time of the survey.

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record reviews and interview, it was determined that the facility failed to complete or submit an adverse incident report for a resident who had a resulting in a bone, for 1 out 2 sampled residents' records reviewed.

The findings included:

A review of the facility's progress notes revealed that Resident #2 while trying to get out of her bed on . The resident was transported to the hospital and was found to have sustained a of her left bone. The progress notes document that surgery was not performed on the resident's hip due to the resident's debilitated condition. The progress notes further documented that Resident #2 was returned to the assisted living facility on with orders for bed rest, and was under continuous care from the resident's hospice provider until .

During an interview on with the Administrator, she confirmed the above information. The Administrator also confirmed that she had no adverse incident report to provide to the surveyor because none had been completed.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Home Sweet Home Assisted Living
6981 Coolidge Street
Hollywood, FL 33024

Dear Administrator:

This letter reports the findings of a State Relicensure Survey that was conducted on , 2016 by a representative from 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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