STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943057	**08/19/2016**
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

A complaint (CCR #2016005627) survey was conducted from , 2016 and concluded on 19, 2016. My Sweet Home with limited nursing services component, license number 8528, had the following deficiencies identified at the time of the survey:

0025 Resident Care - Supervision

Based on interview and record review, the Assisted Living Facility failed to maintain a written record, updated as needed, of any significant changes, that resulted in the provision of additional services for one (Resident #9) out of nine sampled residents.

Findings included:

In an interview on at 11:15 AM Caregiver B reported that Resident #9's husband arrived to facility and wanted to take Resident #9 out of the facility. Caregiver B called the ambulance because Resident #9 complained of not feeling good. Resident #9 returned the same day and Resident #9's husband returned to facility and became verbally aggressive. Caregiver B called the Administrator, informed the Administrator regarding the incident, and Administrator called police. The police called rescue and Resident #9 and Resident #9's husband.
In an interview on at 2:24 PM Caregiver A revealed that Resident #9 was living in the facility for almost three months. The day of the incident Caregiver was off. Resident #9 tried in multiple times, more than one time to wander from the facility but Resident #9 was unable to because the Caregivers were continuously checking on them. The Administrator was informed about the resident's multiple attempts of wandering off.
In an interview on at 2:27 PM Caregiver B revealed that Caregiver B did not recall how long Resident #9 lived the facility. The day of the incident Caregiver B was working alone due to there were only six residents. Caregiver B did not recall that Resident #9 tried to wander off but Resident #9 in multiple times told to the Caregiver that Resident #9 was going to leave. Caregiver B revealed that during Resident #9 stay in the facility caregivers had to call the emergency services because Resident #9 complained of not feeling good

In an interview on at 2:45 PM the Administrator revealed that Resident #9 stayed maximum three months and stayed more in the hospital that in the facility because Resident #9 was , (a person who is abnormally about their health).

Review of Resident #9's record revealed that there was not a written record for Resident #9 which showed Resident #9's significant changes. Review of facility's record revealed that there was a police

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report completed on

Class III

0160 Records - Facility

Based on record review and interview, the Assisted Living Facility (ALF) failed to have an up-to-date admission and discharge log listing the names of all residents.

Findings included:

Review of facility's admission and discharge log revealed that ALF did not include Resident #9 .

In an interview by phone on at 11:04 AM the Administrator revealed that Consultant was supposed to add Resident #9 in the admission and discharge log.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, , 2016

Administrator
My Sweet Home
11312 Sw 203 Terrace
Miami, FL 33189
RE: CCR #2016005627

Dear Administrator:

This letter reports the findings of a Complaint licensure survey that was conducted on
19, 2016 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. **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 surveyor(s). Should you have any questions please call Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

XG90

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