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

A complaint (CCR #2016005728) revisit survey was conducted from , 2016 and concluded on , 2016. My Sweet Home with limited nursing services component, license number 8528, had the following deficiencies identified at the time of the survey:

0093 Food Service - Dietary Standards

Based on observation and record review, the Assisted Living Facility failed to note substitutions in menu before or when the meal is served.

Findings included:

Observation on at 11:41 AM revealed that Residents #1, #2, #5 and #6 and Day Care Participant had been served for lunch white rice, black beans, mixed salad (coleslaw and carrots), pork, and gelatin.

Review of menu posted in the bulletin board revealed that there were Spanish and English menu, but they were planned for week - . It was in menu for : Ziti (1 cup) with ham and cheese (4 oz.) pork, green beans (1/2 cup) dinner roll (1), mixed salad (1 cup) and salad dressing (1T), peaches (1/2 cup).

Class III
Uncorrected

0162 Records - Resident

Based on record review and interview, the Assisted Living Facility failed to have a resident record for one (Resident #9) out of nine sampled residents.

Findings included:

Review of Resident #9's record revealed that there was no resident record for Resident #9 in the facility at the time of the record.

In an interview on at 2:08 PM the Administrator revealed that Administrator was unable to find Resident #9's record.

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)

Class III
Uncorrected

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11943057 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MY SWEET HOME	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0008	Correction	ID Prefix A0010	Correction	ID Prefix A0077	Correction
Reg. # 429.26(4-6) FS; 58A-5.0181(2) FAC	Completed	Reg. # 429.26(1&9) FS; 58A-5.0181(4) FAC	Completed	Reg. # 429.176 FS; 58A-5.019(1) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0079	Correction	ID Prefix A0167	Correction	ID Prefix AN277	Correction
Reg. # 58A-5.019(3) FAC	Completed	Reg. # 58A-5.025 FAC	Completed	Reg. # 58A-5.031(2) FAC	Completed
LSC		LSC		LSC	
ID Prefix AZ815	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 408.809, 435.02(2), 435.06	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 9/1/16	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?
6/27/2016	☐ YES ☐ NO

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

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