STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966724	R
NAME OF PROVIDER OR SUPPLIER **MY SWEET HOME II**	STREET ADDRESS, CITY, STATE, ZIP CODE **214 NW 120 AVENUE** **MIAMI, FL 33182**	

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

0000 Initial Comments

A Standard Biennial Revisit Survey was conducted on 08/17/16 and concluded on . My Sweet Home II (License #10875) with Limited Nursing Services component had the following deficiencies at the time of the survey:

0053 Medication - Administration

Based on record review and interview, the facility failed to ensure that licensed personnel administered medications to one out of six sampled residents (Resident #1).
Findings included:
During an interview on at 8:38 AM Resident #1 stated "staff give my medication in my mouth."
Record review on of Resident #1's health assessment dated / showed that she need assistance with self-administration of medications.
During an interview on at 8: 40 AM, Staff (caregiver/ administrator) stated "I punched the bingo card for hospices residents on to the spoon, take the spoon with my hands, and put it on to residents' mouth. She stated "I'm not a nurse." She stated that residents' hands tremble and this way I did make sure those residents have their medication and breakfast."
Class III

0079 Staffing Standards - Levels

Based on observation, record review, and interview, the facility failed to have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs.
Findings included:
On at 7:00 AM upon arrival to the facility contacted facility phone number to open the facility locked gate. The Staff C (caregiver) did answer the phone and was informed of the purpose of the visit then hung up.
On at 7:11 AM second time called the facility phone number, no one answer the phone. On at 7:14 AM third time called the facility phone number, no one answer the phone. On at 7:16 AM fourth time called the facility phone number, no one answer the phone.
On at 7:30 AM Staff C finally unlocked the gate, at the time of entrance to the facility was found Staff C (caregiver) alone at the facility with six residents. Four hospice residents, one wheelchair bound and one that needs walker assistance to transfer.
The facility owner stated on at 7:30 AM that Staff C (caregiver) was scared to open the door. She stated she was assisting the residents with activities of daily living (ADLs).
Record review on showed the facility staffing pattern for 2016, Staff B

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966724	R 08/29/2016
NAME OF PROVIDER OR SUPPLIER **MY SWEET HOME II**	STREET ADDRESS, CITY, STATE, ZIP CODE **214 NW 120 AVENUE** **MIAMI, FL 33182**	

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

(/caregiver/administrator) from 7:00 AM to 7:00 PM, Staff C from 9:00 AM to 6:00 PM.
Resident record review on showed Resident #1's the health assessment dated / showed that she need assistance with ambulation, bathing, dressing, toileting, and transferring. Resident #1 was an elopement risk. Additional comment the Resident #1 "under Hospice care" and needed " precautions."
Resident #2's health assessment dated / showed that resident needs assistance with all ADLs, "bed bound." Additional comment stated that Resident #2 was "under hospice care" and needed " precautions."
Resident #3's health assessment dated / showed that she needs assistance with ambulation, bathing, self-care, toileting, transferring, and supervision dressing and eating. Additional comment stated Resident #3 was "under hospice care" and needed " precautions."
Resident #4's health assessment dated / showed that she needs assistance with ambulation, bathing, dressing self-care, toileting, transferring, and supervision with eating. Additional comment stated Resident #4 was "under hospice care and needed " precautions."
Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, the facility failed to provide a safe and clean living environment to facility residents.
Findings included:
During facility tour on at 7:35 AM was observe in # a hospice resident in bed and to the left side a big hole. # did have strong smell.
During an interview on at 7:45 AM, the facility's Administrator stated "I had a claim with the insurances and that why the hole still open."
Class III

Z824 Right of Inspection: inspection reports

Based on observation, record review, and interview, the facility provider failed to provide immediately access to the facility. The facility provider failed to give right of inspection to staff the time of the survey.
Findings included:
On at 7:00 AM upon arrival to the facility contacted facility phone number to open the facility locked gate. The Staff C (caregiver) did answer the phone and was informed of the purpose of the visit then hung up.
On at 7:11 AM second time called the facility phone number, no one answer the phone. On at 7:14 AM third time called the facility phone number, no one answer the phone. On /

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966724	R 08/29/2016
NAME OF PROVIDER OR SUPPLIER **MY SWEET HOME II**	STREET ADDRESS, CITY, STATE, ZIP CODE **214 NW 120 AVENUE** **MIAMI, FL 33182**	

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

at 7:16 AM fourth time called the facility phone number, no one answer the phone.
On at 7:30 AM Staff C finally unlocked the gate, at the time of entrance to the facility was found Staff C (caregiver) alone at the facility with six residents. Four hospice residents, one wheelchair bound and one that needs walker assistance to transfer.
On at 7:30 AM the facility's Owner stated that Staff C was scared to open the door. She stated she was assisting the residents.
During the facility tour on at 7:35 AM the facility staff locked. The survey tour, the Surveyor was not allowed on this facility area.
During an interview on at 7:40 AM, the facility's owner stated" my husband is a truck driver and he had the key. I did not have way to open the door now. he had the key with him."
Unclassified

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11966724 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MY SWEET HOME II	214 NW 120 AVENUE MIAMI, FL 33182

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 Reg. # 429.176 FS; 58A-5.019(1) FAC LSC	Correction Completed	ID Prefix A0078 Reg. # 58A-5.019(2) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE 9/13/14	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 6/27/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: 60GT12

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
My Sweet Home Ii
214 Nw 120 Avenue
Miami, FL 33182

Dear Administrator:

This letter reports the findings of a Standard Biennial revisit survey conducted on , 2016by 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,

Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

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