

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 11/03/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966724	(X3) DATE SURVEY COMPLETED R 10/20/2016
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)

0000 Initial Comments

A Standard Biennial Second Revisit Survey was conducted on 10-19-2016 and on 10-20-2016 at My Sweet Home II (License #10875) with Limited Nursing Services component. At the time of survey there was one deficiency found uncorrected.

0053 Medication - Administration

Based on record review and interviews the facility failed to that residents who could no longer assist with self-administrator had a licensed staff member administer medications to them.

Findings included:

Reviewed facility's medication observation record (MOR) Employee C (Caretaker) assisted hospice residents (#1/2/3/4) with their medications in the morning.

On 10/20/2016 at 1:30 PM the Owner called the hospice company and told them the residents could not take their medications.

Interviewed Employee C on 10/20/2016 at 12:30 PM she stated that neither of the hospice residents can take their medications without assistance and she has been assisting with their medications.

The Owner stated on 10/20/2016 that her employees have been assisting the four hospice residents with their medications on many occasions because each of the residents cannot hold the cups with their medications in them and this is why the facility staff has been assisting the residents with their medications. Staff place the medications on spoons. The Residents cannot hold the medications in the cups because the lack of control of their hands which they shake too much and would spill their medications without the assistance of her staff.

Uncorrected Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11966724	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT Y1 Y2 Y3
NAME OF FACILITY MY SWEET HOME II	STREET ADDRESS, CITY, STATE, ZIP CODE 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 A0079	Correction	ID Prefix A0152	Correction	ID Prefix AZ824	Correction
Reg. # 58A-5.019(3) FAC	Completed	Reg. # 58A-5.023(3) FAC	Completed	Reg. # 408.811 FS, 59A-35.120 FAC	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	
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) <i>JS</i>	DATE 11/6/16	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



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

January 15, 2016

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

Dear Administrator:

This letter reports the findings of a **second** Standard Biennial Licensure Revisit Survey conducted on January 15, 2016 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

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 January 15, 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(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

YOSF

