

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 01/04/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967505	(X3) DATE SURVEY COMPLETED 12/21/2016
NAME OF PROVIDER OR SUPPLIER HOME SWEET HOME ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 SW 46 TERRACE MIAMI, FL 33155	

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

0000 - Initial Comments

A Standard Biennial survey was conducted on 12-21-2016 at Home Sweet Home Assisted Living Facility. There was a deficiency found at the time of the survey: (Lic# 11556)

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on record review and interview, the facility failed to provide documentation that one out of five sampled employees (E) had eight hours of training in limited mental health (LMH).

Findings included:

Record review revealed employee (E) was hired on - , and there was no documentation of completion of the training for Limited Mental Health.

Interviewed on - at 12:30 PM, the Administrator stated that the employee shall be scheduled for the next LMH training as soon as possible.

Class III



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

Administrator
Home Sweet Home Assisted Living Facility Corp
5700 Sw 46 Terrace
Miami, FL 33155

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 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 , 2017.** 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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,


Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure

XG90

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