STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968499	06/06/2017
NAME OF PROVIDER OR SUPPLIER **AM SWEET HOME ALF, CORP**	STREET ADDRESS, CITY, STATE, ZIP CODE **13066 SW 187 STREET** **MIAMI, FL 33177**	

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

0000 - Initial Comments

A Standard survey was conducted on . AM Sweet Home ALF with Standard license (AL12397) had the following deficiencies identifies at the time of the survey:

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on observation, record review, and interview the facility failed to provide documentation of an updated health assessment done by healthcare provider after a significant change for 2 out of 4 sampled residents (Resident # 1 and #2).

Findings Included:

A review of Resident #1's file revealed the resident was Admitted on , AHCA Health Assessment dated showed diagnoses of , , , , major , , post , , , post-concussion , , hematoma, with behavioral disturbance, , , , ataxia. The resident is and agitated hallucinates. The resident needs supervision with ambulation, assistance with bathing and dressing, independent with eating and self-care , needs supervision with toileting, and is independent with transferring. Per health assessment the resident was an elopement risk and was recommended to have continuous supervision for preventing and unauthorized exiting the premises. Photo identification was not in file.

On at 11:08 AM Observed staff C spoon feeding Resident #1.

On at 11:15 AM Staff C Stated "Resident #1 is not able to walk, she is not able to get up from her wheelchair and be weighed."

A review of Resident 2's file revealed the resident was admitted on , AHCA Health Assessment dated showed diagnoses of , , major , , , and . Resident is alert. The resident is independent with ambulation, supervision with eating, assistance with dressing, independent with eating, assistance with self-care , independent with toileting and transferring. The resident needs assistance with self-administration of medications. Per health assessment the resident is not an elopement risk. Photo identification was not in file.

A review of Resident #2's Progress notes dated documented that "The resident was very , walking around & hyper. She was walking to the front door & by herself, staff came to

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evaluate her. She had by her head, she was awake and responding. Family and physician were informed. The Resident was under observation by staff. On she had a around her neck & on her head; she was transferred to Larkin Hospital for evaluation. She had many exams & X rays and everything was okay. She was back on the same day. Progress note dated documented that on she had on her head; she was transferred to Baptist Hospital. She had too. She got her for at the hospital and she was ordered for 7 days, twice a day."

On at 2:12 PM Observed Resident #2 walk towards the door, opened the door and tried to go outside. Staff C went after her and escorted the resident back in the home.

On at 3:26 PM Administrator stated "Resident #2 has never done that, she was becoming and I notified the doctor and he prescribed , 5 MG twice a day for agitation. She had a because she was and she lost her balance, tripped on her shoes and , she was transferred to Larkin Hospital and she was under observation and she was discharged the same day.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on observation, record review and interview the facility failed to follow policies and procedures when responding to residents at rwask for elopement.

Findings included:

A review of Resident #1's file revealed the resident was admitted on . AHCA Health Assessment dated showed the resident was an elopement rissk and was recommended continuous supervison for preventing and unauthorized exiting the premises. Further review of the resident's file revealed photo identification of the resident was not on file.

A review of Resident #2's file revealed the resident was admitted on , AHCA Health Assessment dated showed that the resident was not an elopement rissk. Further review of the resident's file revealed photo identification of the resident was not in file.

On at 2:12 PM Observed Resident #2 walk towards the door, opened the door and tried to go outside. The Staff C went after her and escorted the resident back in the home.

On at 3:26 PM Administrator stated "Resident #2 has never done that, she was becoming

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and I notified the doctor and he prescribed , 5 MG twice a day for agitation. She had a because she was and she lost her balance, tripped on her shoes and , she was transferred to Larkin Hospital and she was under observation and she was discharged the same day.

On at 2:30 PM observed that Resident #1 and Resident #2 did not have bracelet or other identifiers.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview the facility failed to file an incident for 1 out of 5 sampled residents (Resident #2)

Findings include:

Review of Resident #2's Progress notes dated had documentation stating "The resident was very , walking around & hyper. She was walking to the front door & by herself, staff came to evaluate her. She had by her head, she was awake and responding. Family and physician were informed. The Resident was under observation by staff. On she had a around her neck & on her head; she was transferred to Larkin Hospital for evaluation. She had many exams & X rays and everything was okay. She was back on the same day. Progress note dated was documented stating on she had on her head; she was transferred to Baptist Hospital. She had too. She got her for at the hospital and she was ordered for 7 days, twice a day."

On at 3:26 PM Administrator stated "Resident #2 has never done that, she was becoming and I notified the doctor and he prescribed , 5 MG twice a day for agitation. She had a because she was and she lost her balance, tripped on her shoes and , she was transferred to Larkin Hospital and she was under observation and she was discharge the same day.

On at 3:31 PM Administrator stated "I did not do an incident report because Resident #2 was taken to the hospital and she was released the same day."

Review of the AHCA internal website revealed there was no incident report completed for Resident #2.

Class III