STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964442	**03/06/2018**
NAME OF PROVIDER OR SUPPLIER **A SWEET ALF, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **18400 NW 81 COURT** **HIALEAH, FL 33015**	

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

0000 - Initial Comments

A Standard Biennial survey was conducted on , 2018. A Sweet ALF, Inc (License # 9159) with Limited Mental Health components had the following deficiencies identified at time of the survey:

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review and interview, the facility failed to have updated notes for one of five sampled residents (#1). The facility failed to show action taken after Resident #1's .

Findings included:

Observation on at 8:40 am revealed Resident #1 sitting in the Family TV.

On at 8:50 am Staff B stated, "Resident #1 and went to the hospital two month ago. Therefore, family decided to put her on hospice."

On at 12:39 pm Resident #1's family member stated, "Resident #1 lives in the facility for two years. I have not heard about her falling. She went to the hospital for a ( )."

On at 1:56 pm Resident #2 stated, "I have been here like 13 or 14 years. Resident #1 and we called 911, but she was transported by the ambulance. She is doing well."

On at 1:43 pm, Resident #3 stated, "I have two years living here. Resident #1 in the facility, but I do not remember when it happened, and she has not since that time. I remember that she walked to the Florida Area and slipped with her feet and dropped sitting on the floor. The ambulance came and took her to the hospital."

A review of Resident #1's file revealed that there was no documentation regarding her , hospitalization or action taken after .

On during the exit conference Staff A confirmed that Resident #1 and the family member was informed. Staff A further stated Resident #1 did not have injuries and went to the hospital, and she is doing well. Staff A stated "I have all my progress notes of everything that happened with my residents, as you see, I have everything here; however, I forgot to write Resident #1's and hospitalization information."

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Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation and interview the facility failed to provide assistance with self-administration of medication according to the procedures outlined by the state for two of five sampled residents (Residents #2 and #3).

Findings included:

Observation on at 9:20 am showed that Staff B had Resident #3's medications (C 500 mg, , 75 mg, , 10 mg, , 81 mg, Polyethylene Gly , , 20 mg and 1000 mg) inside of a plastic cup. While Resident #3 was sitting on the dining table, Staff B placed the cup next to the resident's breakfast and walked away toward the kitchen.

Observation on at 9:21 am showed that Staff B poured all the medications (50 mg, SOD 100 mg, , 81 mg, , 50 mg, 90 mcg and 2 mg) from 8:00 am in a plastic cup and called Resident #2 from the kitchen window. Resident #2 stood in front of the window and took his cup with the medications and cup of water. Staff B stepped out from the kitchen. Resident #2 swallowed the pills and walk out.

Observation on at 9:20-9:21 am showed that Staff B did not use the Medication Observation Record (MOR) before and/or after provided assistance with self-administrator to Resident #2 and #3's medications.

On at 3:30 pm Staff B confirmed that she put Resident #3 medications into a cup on the dining table while Resident #3 was having breakfast and walked away. Staff B also confirmed passing Resident #2's medications through the kitchen window and walking out from the kitchen. Staff B confirmed that she did not used the MOR.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, record review and interview, the facility failed to sign the medications as given for two of sampled residents five (Residents #2 and #3).

Findings included:

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Observation on at 9:20-9:21 showed am Staff B did not use the Medication Observation Record (MOR) while providing assistance with self-administrator to Resident #2 and #3's medications.

Record review revealed that Staff B signed Resident #3' MOR before assisting with self-administration of the following medications: C 500 mg, 75 mg, 10 mg, 81 mg, Polyethylene Gly, 20 mg and 1000 mg inside of a plastic cup.

Record review revealed that Staff B signed Resident #2' MOR before assisting with self-administration of the following medications: 50 mg, SOD 100 mg, 81 mg, 50 mg, 90 mcg and 2 mg inside of a plastic cup.

On at 3:30 pm Staff B stated, "I signed the MOR before medications because Resident #3 was getting ready to have her breakfast." In addition, Staff B stated, "I also signed Resident #2 medications because I wait for him, too."

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview the facility failed to provide evidence of a negative examination on an annual basis for three of four sampled staff (Staff A, C and D).

Findings included:

Record review revealed that there was no documentation of a current freedom from statement on file for Staff A (hired).

Record review revealed that Staff C's (hired) last statement was dated .
There was no documentation of a current freedom from statement.

Record review revealed that Staff D's (hired) last statement was dated .
There was no documentation of a current freedom from statement.

On at 3:50 pm Staff A stated, "Yes, I am aware that we are missing updated statements in our file."

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Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to provide an environment free of hazards for five of five sampled residents (Residents # 1-5).

Findings included:

Observation on at 3:35 pm revealed:

The backyard had more that ten bicycles behind a storage den. There was also discarded furniture and sheets. There were 30 tiles and work instruments and other debris.

Interview on at 12:39 pm Participant #1 stated, "They need to fix the landscaping, drive through way and paint outside."

Interview on at 2:00 pm Staff A stated, "I am renting this house." Staff C stated, "The owner of these bicycles is Resident #1 and he called the agency, and they said that he can have them."

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the facility failed to have an accurate health assessment for two of five sampled residents (#1 and #2).

Findings included:

Record review revealed that Resident #1 was admitted on hospice on . Resident #1's health assessment (dated) did not reflect hospice services.

Record review revealed that Resident #2's health assessment (dated) had the medication administration section blank.

Interviewed on at 3:52 pm, Staff A acknowledged that Resident #2 had the medication administration section blank and Resident #1's health assessment did not reflect hospice services. Staff A stated, "I requested them a new 1823 that reflected that information."

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Class III