STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967484	**10/10/2018**
NAME OF PROVIDER OR SUPPLIER **SWEETEST HOME INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **482 NW 26TH AVENUE** **MIAMI, FL 33125**	

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

0000 - Initial Comments

A standard biennial survey was conducted on , 2018. The Sweetest Home Inc (the) with limited mental health component (license #11514) had the following deficiencies identified at the time of the survey:

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

Based on record review and interview, the Assisted Living Facility failed to maintain updated Medication Observation Record (MOR) for one out of 15 sampled residents (#13).

Findings included:

Review of Resident #13's MOR showed that there was an order for , 1 mg tablet take one tablet by mouth in the afternoon. It showed scheduled at "12". Staff initialed the medication on the 1st, 2nd and 3rd of . There was an order for , 0.5 mg tablet take one tablet by mouth in the afternoon. It showed scheduled at "12". There was an order for , 0.5 mg tablet take one tablet by mouth in the afternoon. Staff did not initial the medication on the 1st, 2nd and 3rd of . There was an order for Sulf 325 mg tab take one tablet by mouth daily. It was scheduled at 12 AM. Staff initialed the medication on .

Medication reconciliation for Resident #13 showed that , 1 mg tablets missed from the medication card for 1, 2, 3, 4, 5, 6, 7, 8, and 9. , 0.5 mg tablets missed from the medication card for 1, 2, 3, 4, 5, 6, 7, 8, and 9. Sulf 325 mg tablets missed from the medication card for 1, 2, 3, 4, 5, 6, 7, 8, and 9.

On at 2:51 PM, Staff C revealed the was scheduled at the middle of the night but the resident was taking in the morning. Staff D already fixed it. She was aware of couple of other medications that missed initials in the MORs by the other staff.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation and record review, the Assisted Living Facility failed to maintain a written work schedule that reflected its 24-hour staffing pattern.

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Findings included:

On at 7:20 AM, Staff C and I were on duty. On at 7:58 AM, Staff D arrived and at 8:35 AM, Staff F arrived.

Review of staffing pattern showed that it covered from to . Staff C worked Monday thru Friday from 6 AM to 3 PM. Staff D worked from Tuesday to Sunday from 7 AM to 4 PM. Staff F worked Monday thru Thursday and Sunday from 9 AM to 6 PM. Staff I worked from 12 AM to 9 AM on Monday, Tuesday, Friday, Saturday, and Sunday. Staff J worked from 3 PM to 12 AM on Tuesday and Thursday, from 8 AM to 5 PM on Wednesday, and from 9 AM to 6 PM on Friday.

On at 2:50 PM, the Administrator revealed Staff D ran late this morning. Staff J worked Tuesday from 8 AM to 5 PM instead of Wednesday but she did not change the schedule.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that staff received training in topics pertinent to nutrition and food service in an assisted living facility by a certified food manager, licensed dietician, registered dietary technician or health department sanitarian qualified to train assisted living facility staff in nutrition and food service for two out of ten sampled staff (G, J).

Findings included:

Review of Staff G's personnel record showed that hire dated was . The food and nutrition training had a copy of trainer's signature and date on . Review of Staff J's personnel record showed that hire dated was . The food and nutrition training had a copy of trainer's signature and date on . Record review found the facility failed to provide evidence that the training was completed by a licensed dietitian.

On at 1:21 PM, the administrator revealed Staff G covered the kitchen when Staff D was off.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and record review, the Assisted Living Facility failed to note substitutions before or

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when the meal was served.

Findings included:

On at 8:12 AM, breakfast observations found residents were served coffee with milk, oatmeal, crackers, and water.

On at 8:19 AM, Resident #13 stated, "I don't like crackers."

Reviewed of menu on at 8:19 AM showed for breakfast on assorted juices (4 oz.), dry cereal (¾ cup) or cooked (1/2 cup), bread (1 slice), margarine (1 spoon) and milk (8 oz.). There was no documentation about substitution.

On at 8:23 AM, Staff D revealed that breakfast was the oatmeal provided with banana and milk, the crackers that came with butter, coffee with milk for the residents who did not like the cereal.

Class III

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

Based on observation and interview, the Assisted Living Facility failed to have a safe living environment.

Finding included:

On at 7:35 AM, there was a white patch in the back kitchen ceiling. There a dark brown stain over the white patch.

On at 7:35 AM, the Staff C revealed that staff cook in that area for the residents.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the Assisted Living Facility failed to document the reason for discharge in the admission and discharge log for one out of 15 sampled residents (#2). The facility failed to document the facility or place from which the resident was admitted for four out of 15 sampled residents (#9, #10, #13, and #15).

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Findings included:

Review of admission and discharge log showed the facility entered Resident #2 on one page with no admission date just with as discharge date. There was no reason for discharge. Resident #2 was on other page of the admission and discharge log with admission date on and no discharge nor reason of discharge.

Review of admission and discharge log showed that Resident #9's admission date was on . There was no documentation about the facility or place from which the resident was admitted.

Review of admission and discharge log showed that Resident #10's admission date was on . There was no documentation about the facility or place from which the resident was admitted.

Review of admission and discharge log showed that Resident #13's admission date was on . There was no documentation about the facility or place from which the resident was admitted.

Review of admission and discharge log showed that Resident #15's admission date was on . There was no documentation about the facility or place from which the resident was admitted.

On at 10:17 AM, the Administrator revealed Resident #2 the last Friday under hospice service. Residents #9 and #10 was in the facility when she started as administer of the facility. Resident #13 knew that she came from her house. Resident #15, "I think that came from his house."

Class III

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

Based on record review and interview, the Assisted Living Facility failed to record resident's weight semi-annually for two out of 15 sampled residents (#15 and #13). The facility failed to have a current interdisciplinary care plan for one out of 15 sampled residents (#15).

Findings included:

1. Review of Resident #15's record revealed that health assessment was completed on . The resident needed total care on all activities of daily living (ambulation, bathing, dressing, eating, , transferring and toileting). The resident's admission date to hospice was . Last weight recorded in the record was dated " " and it was 147 pounds.

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On at 11:43 AM, the Administrator revealed that hospice weighted the resident and the weight in record was too old.

Review of Resident #13's record revealed that health assessment completed on . The resident needed assistance with bathing, dressing, and . The weight record showed that on was 151 pounds, on was 150 pounds, on was 148 pounds and on was 151 pounds.

2. Review of Resident #15's record revealed that the resident's admission date to hospice was . Last Interdisciplinary Team (IDT) covered from to . Last plan of care covered from to .

On at 2:57 PM, the Administrator revealed that the nurse from hospice left that date on vacation and informed her that the plan of care was on record. She could not find it.

Class III