STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968499	**05/03/2019**
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 Re-Licensure Survey was conducted on , , to , , . Deficiencies were identified at the time of survey.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and interview, the facility failed to ensure that one of six sampled residents met admission criteria.

Findings included:

On , , at 8:10 AM, inside empty Room number 5, observed two boxes of medications for Resident 7 inside a drawer, inhaler solution .083% Inhale one ampule via every six hours as needed for and , , inhalation solution .02% every six hours as needed.

On , , at 8:10 AM, Staff B stated, "Those are from a resident who is no longer with us."

On , , at 11:35 AM, the Administrator stated, "That was a resident who was only here for few days, I sent him to the hospital."

Review of the facility's admission/discharge log did not show the name of the resident with the date of admission, discharge date and place of discharge.

On , , at 11:35 AM, the Administrator stated, "That was a resident who was only here for few days, I sent him to the hospital, he did not look good and I sent him. When the administrator was requested to provide the resident record, she did and the record showed an admission date .

Review of Resident 7's record showed an health assessment dated . to , pork, , . A diagnoses of , , , , , , , , . Can follow commands. precautions, , . No elopement risk. Assistance with all activities of daily living. The Administrator 12:10 pm, stated, "He went to the hospital in an ambulance that we called; the daughter requested that we send him. He did not want to eat, to swallow. I called the daughter to see how he was doing and days later, he . . He left on ."

On , , at 2:25 PM, the Administrator stated, "He was too weak and did not want to eat. When

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he came in, he was Ok. I know the dates but I do not exactly where he went. I do not have his medication record. I am not sure of the date of hospitalization.

Hospital record for the resident showed admission to intensive unit , discharged ( ). Chief complaint, , failure, not eating for the last 3 days. Acute injury (defined as increase in certain serums and volume) , acute hypernatremia, acute , failure. Discharge disposition, expired. Confirmed active , acquired lymphedema, , dyslipidemia, advanced age and skin . Most test results were either higher or lower than normal range. Diagnoses - , and hypernatremia.

On , at 5:30 PM, a family member stated, "He was at the Rehabilitation hospital before going to the assisted living facility (ALF), he was in a wheel chair but he could not transfer himself. He was receiving , that we did not know anything about it. I spoke to the doctor at the hospital and he told me that he was in the emergency room, it was 8:00 PM; he had a lot of , an and other things when he was at the rehab. The doctor at the rehabilitation signed the Ok to go to an ALF.. On Friday, they call this man and he came to evaluate him for nursing home but they released him. He was at the rehabilitation hospital for 2 weeks."

On , at 7:56 PM, a family member stated that the father was Ok the first day and the next day he was in bed. "A week later, the owner called and said that they could not take care of him anymore; that it took three staff to get him up, that he could not get up and stand by himself. I contacted a hospice company and they were going to visit him to do an assessment. When I called the owner to let her know, she got upset and told me that she had another company that she wanted to use that he could not get the services yet as he was receiving , . My dad was alive when he arrived to the hospital around 5:00 PM and stopped breathing around 7:00 PM."

On , at 10:20 AM during a phone interview with the home health company representative giving , services to the resident while at the facility stated, "The doctor from the rehabilitation center where the resident was prior to the ALF, requested the , on ; the notes say that he was wheel chair dependent, unable to transfer, unable to ambulate with risk of and that he was a good for improvement on bed mobility. The last , was on and discharged , he left to the hospital."

Class III

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

Based on record review and interview, the facility failed to maintain up-to-date documentation for one of seven sampled residents, (Resident 7) who had significant health changes during his residency.

Findings included:

On , , at 8:10 AM, inside empty Room number 5, observed two boxes of medications for Resident 7 inside a drawer, inhaler solution .083% Inhale one ampule via every six hours as needed for and , , inhalation solution .02% every six hours as needed.

On , , at 8:10 AM, Staff B stated, "Those are from a resident who is no longer with us."

On , , at 11:35 AM, the Administrator stated, "That was a resident who was only here for few days, I sent him to the hospital."

Review of the facility's admission/discharge log did not show the name of the resident with the date of admission, discharge date and place of discharge.

On , , at 11:35 AM, the Administrator stated, "That was a resident who was only here for few days, I sent him to the hospital, he did not look good and I sent him. When the administrator was requested to provide the resident record, she did and the record showed an admission date . At 2:25 PM, the Administrator stated, "He was too weak and did not want to eat. When he came in, he was Ok. I know the dates but I do not exactly where he went. I do not have his medication record. I am not sure of the date of hospitalization. The Administrator 12:10 pm, stated, "He went to the hospital in an ambulance that we called; the daughter requested that we send him. He did not want to eat, to swallow. I called the daughter to see how he was doing and days later, he . He left on ." On , , at 3:25 PM, the Administrator stated, "When he refused to eat the breakfast, I called the daughter and let her know that I was going to send him to the hospital. I needed to know to what hospital because they did not want him to go to the closest one."

Review of Resident 7's record showed an health assessment dated , to , pork, , . A diagnoses of , , , , , , . Can follow commands. precautions, , , skin. No elopement risk. Assistance with all activities of daily living.

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A review of the resident record showed no documentation of health, behavior changes or services provided during [redacted] and [redacted].

Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC 429.255(1)(b). FS

Based on observation, record review and interview, the facility failed to ensure that the third party care provider coordinated with the facility regarding the resident's condition and the services being provided for two of seven sampled residents (Residents 1 and 3).

Findings included:

1) A review of Resident 1's record showed an admission date of [redacted]. A review of the hospice record showed [redacted] care 3 times/week, however there was no documentation about the resident's progress.

On [redacted] at 10:45 AM, the Administrator contacted the hospice nurse, who stated by telephone, "We put the information in the computer and do not leave anything at the facility."

On [redacted] at 10:45 AM, the Administrator stated, "I was not aware that I was supposed to check their book and also the home health books."

2) On [redacted] at 2:00 PM, observed Resident 3 in his room. The resident was uncovered and had some type of [redacted] on his right [redacted] under the [redacted] and with medical [redacted] on his [redacted]. Staff B immediately covered him and said that he had that not for long and stated, "I just changed his brief; he just stays in bed; they come every two days and the HHA every day to bathe him. He has been in the hospital twice due to [redacted] "

Review of Resident 3's record showed admission date [redacted] and the hospice record showed a referral date [redacted]. The record did not have any progress notes in reference to the [redacted] or hospitalizations.

On [redacted] at 8:50 AM during a phone interview with the hospice nurse, she stated that the notes that they had showed [redacted] a [redacted] on the resident's arm, a [redacted], and a pressure

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. When asked about the visible he had on his , the nurse could not find any notes in their system and stated. "Yes, the nurse had to update the plan of care at that point. We are going to send you by fax the last notes we have on file in reference to what we discussed."

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to return or dispose of medications for one of seven sampled residents, (Resident 7) who was no longer residing at the facility.

Findings included:

On , , at 8:10 AM, inside empty Room number 5, two boxes of medications for Resident 7 inside a drawer, inhaler solution .083% Inhale one ampoule via every six hours as needed for and , , inhalation solution .02% every six hours as needed.

On , , at 8:10 AM, Staff B stated, "Those are from a resident who is no longer with us."

On , , at 11:35 AM, the Administrator stated, "That was a resident who was only here for few days, I sent him to the hospital."

Class III

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

Based on observation and interview, the facility failed to maintain the property free of hazards for all residents and staff.

Findings included:

On , , at 8:30 AM, observed on the left side of the property in the backyard area accessible to residents, a shopping cart, construction debris and black trash bags.

On , , at 8:30 AM, the Administrator acknowledged the situation and stated they were in the process of discarding them.

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Class III

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

Based on record review and interview, the facility failed to maintain an accurate admission and discharge log. Resident 7 was not listed.

Findings included:

Review of the facility's admission and discharge log showed that Resident 7's name, date of admission and date and place of discharge were not listed.

On , , at 8:10 AM during the tour of the facility, two boxes of medications for Resident 7, who no longer resided at the facility, were found inside empty room number 5. The staff stated that the resident was no longer a resident. The administrator acknowledged that the resident was not on the log and when requested, she provided the resident's record. According to the record, the resident admission date was .

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and interview, the facility failed to provide documentation of an application with references for one of four sampled staff, (Staff B).

Findings included:

Review of Staff B's personnel record showed a hire date of . The record did not have an employment application, or references.

On , , at 2:50 PM, the Administrator, in reference to the application and references missing, acknowledged that the records were not available.

Class III.

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

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Based on record review and interview, the facility failed to obtain an updated health assessment for one of seven sampled residents, (Resident 3) who was admitted to hospice care.

Findings included:

Review of Resident 3's record showed an admission date . Last health assessment with assistance in most activities of daily living, supervision with eating. precautions, no elopement risk. A diagnoses of , right replacement, type II, prostatic hyperplasia and .

Review of the resident hospice record showed a referral to hospice dated , a care plan dated and a hospital bed and full bed rail order dated .

On , , at 8:35 AM, the Administrator stated, "The doctor came to see him in and noticed the change; I spoke to him over the phone about a week ago and he sent me the prescription for hospice. He needs to come to see him.

Class III