STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967484	03/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEETEST HOME INC	482 NW 26TH AVENUE MIAMI, FL 33125

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

0000 Initial Comments

A Complaint (2016000677) Survey was conducted on [redacted]. Sweetest Home Inc with Limited Nursing Services and Limited Mental Health components had a deficiency at the time of survey.

0010 Admissions - Continued Residency

Based on observation, record review, and interview the facility failed to conduct as part of the continued residency criteria for residents a face-to-face medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever came first for 4 out of 14 sampled residents (#1, #2, #3, and #4).

Findings included:

During the tour of the facility on [redacted] at 8:45 am observed Resident #1 sitting in a recliner on the covered patio.

Caregiver B stated on [redacted] at 8:40 am Resident #1 was under hospice services and required total assistance with her activities of daily living.

Record review of Resident # 1 revealed that the last Health Assessment (AHCA form 1823)was completed on [redacted] (Health Assessment was more than [redacted]) and at that time resident required assistance with her activities of daily living and was able to ambulate with a rolling walker.

During the tour of the facility on [redacted] at 8:46 am observed Resident #2 sitting in a recliner on the covered patio.

Caregiver B stated on [redacted] at 8:46 am Resident #2 was under hospice services and required total assistance with her activities of daily living.

Record review of Resident #2 revealed that the last Health Assessment (AHCA form 1823)was completed on [redacted] and at that time resident required assistance with her activities of daily living. Record review also revealed the resident was admitted to hospice on [redacted].

During the tour of the facility on [redacted] at 8:47 am observed Resident #3 sitting in a recliner on the covered patio.

Caregiver B stated on [redacted] at 8:47 am Resident #3 was under hospice services and required total

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assistance with her activities of daily living.

Record review of Resident #3's file revealed that the last Health Assessment (AHCA form 1823) was conducted on (Health Assessment was more than) and at that time resident was already under hospice services and requiring total assistance with her activities of daily living.

During the tour of the facility on / at 8:40 am observed Resident #4 lying in his bed in #.

Caregiver B stated on / at 8:40 am Resident #4 refused to get out of bed. She also stated Resident # 4 required assistance with eating and total assistance with the rest of his activities of daily living.

Record review of Resident #4 revealed he has been receiving hospice services since /. Record review of Resident # 4 also revealed that his last Health Assessment (AHCA form 1823) was completed on / and resident required assistance with all his activities of daily living.

The facility's administrator stated on / at 12:45 pm she did not know that she needed a new health assessment (AHCA form) 1823 after a significant change or every 3 years and that she would get in contact with the doctor to come to the facility and update the health assessments.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Sweetest Home Inc
482 Nw 26th Avenue
Miami, FL 33125
RE: CCR #2016000677

Dear Administrator:

This letter reports the findings of a complaint 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 , 2016.** 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 Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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