Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966213	A. BUILDING: _____ B. WING _____	06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TL SEA HOME CARE SERVICES	14031 SW 39 ST MIAMI, FL 33175

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number # 2021007718) was conducted at TL Sea Home Care Services on to . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of ... or ... , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , ... The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making ... for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a general awareness of the resident's whereabouts for one out of six (Resident #1) sampled residents. Findings included: A review of Resident #'s #1 health Assessment dated [redacted] showed the resident has a diagnosis of [redacted]'s, Debility, [redacted] ([redacted]), and [redacted]. The physician indicated the resident required assistance with all activities of daily living (ambulation, bathing, [redacted], eating, self-care	A 025		

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A 025	Continued From page 2 (grooming), toileting, and transferring). The physician indicated the resident did not have risk of elopement. Interview conducted on at 10:34 AM, Administrator stated Resident #1 used to come and go from the facility. The resident would go shopping. She usually returned to the facility by 6:00 PM. On the day of the elopement ( ), the resident told her that she was going to the bank to get money to pay the facility rent, but she never returned. She stated that a police report was done. The resident was found in a rehabilitation facility on . Interview conducted on at 2:18 PM, Staff C stated "In , she (Resident #1) went to her friend house. She left in the middle of the day, and she did not return. We reported to the police. She took her medications that day in the morning. She used to go to the store." Class III	A 025		
A 027 SS=D	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , , and remind residents about scheduled , , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation.	A 027		

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A 027	Continued From page 3 (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to arrange heath care to in order to facilitate resident access to home health services for one out of six sample residents (Resident #1). Finding include: A review of Resident #1 1823 health assessment dated showed the resident has a medical history and diagnosis of: 's, Debility, , Track ( ), and , . The resident required assistance with self-administration of medications. A review of Resident #1 Medication Observation Record for , the record showed that the resident had two active medication orders that required the services of a Home Health Agency for its administration. The medications were: 1. 100 units administer 20 units (SQ) each day (medication). 2. Ozempic administer 0.25 mg SQ once a week (medication). On at 10:53 AM, Staff A stated Resident #1 refused to take both and Ozempic. On at 11:49 AM, Staff A stated that Resident #1 primary health care provider (Physician A) was notified that the resident was refusing her medications. Staff A also stated that Resident #1 refused Home Health Agency services as it pertains to the	A 027		

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A 027	Continued From page 4 administration of [redacted] and Ozempic. On [redacted] at 12:37 PM, Staff A stated that Resident #1 stated "I am not [redacted], I have never had [redacted] in my life. Staff A stated that Physician A educated the resident about the reason to take the medications. On [redacted] at 1:53 PM, a home health representative stated Resident #1 was provided with [redacted] and [redacted] for medication administration, the representative stated "I never got an [redacted] order". A review of Resident #1 observation log on [redacted], the log showed that there was no documentation indicating the arrangement of home health services, no documentation the resident refuse home health services, no documentation the resident refuse to take the [redacted] and Ozempic medications, and no documentation resident physician informed of resident refusal of medications. Class III	A 027		
A 054 SS=E	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication	A 054		

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A 054	Continued From page 5 observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Medication Observation Record (MOR) was immediately updated each time the medication is offered or administered for each resident who receives assistance with self-administration of medications four out of six sampled residents (Resident #1, Resident #4, Resident #5, and Resident #6). Finding include: A review of Resident #1 MOR for showed no documentation whether Resident #1 received the 8:00 AM medications on . In an interview with Staff C on at 2:18 PM, Staff C stated that she gave Resident #1 her	A 054		

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A 054	Continued From page 6 morning medications on . . . . . . A review of Resident #4 MOR for . . . . . showed no documentation whether Resident #4 received the 8:00 AM medications on . . . . . . A review of Resident #5 MOR for . . . . . showed no documentation whether Resident #5 received the 8:00 AM medications on . . . . . . A review of Resident #6 MOR for . . . . . showed no documentation whether Resident #6 received the 8:00 AM medications on . . . . . . In an interview with Staff B on . . . . . at 9:24 AM, Staff B stated, "I could not sign the medication book this morning due to complications with the hospice resident". Class III	A 054		