| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11965295 | R |
| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| TLC III | 8395 SW 112 STREET<br>MIAMI, FL 33156 | |

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

**0000 - Initial Comments**

A Monitoring survey was conducted on . TLC # III had deficiencies at the time of the survey.

**0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC**

Based on observation, interview, and record review, the facility failed to follow admission licensure standards and determine the appropriateness for continued residency for 3 of 7 sampled residents (Residents #3, #4 and #5). This was evidenced by the facility's failure to properly assess, monitor and document the required nursing care and services for 3 of 7 sampled residents ( Resident #3, #4, and #5) who required total care due to a declining medical condition. The facility failed to ensure that 3 of 7 sampled residents (Residents #3, #4, and #5) had an accurate and completed health assessment with significant change in medical condition.

The findings included:

1. Review of Resident # 3's medical record indicated medical diagnoses including advanced and , history of ( ), , visual and . Resident #3's health assessment dated on indicated that the resident was non-ambulatory and required total assistance with all of her activities of daily living (ADL) care including eating. The resident required a pureed diet with thickened liquids and precautions. The assessment indicated Resident #3 required assistance with self-administration of her medications.
In an observation of Resident #3 on at 9:50 AM, the resident was sitting in a wheelchair, she was asleep, hunched over with her chin touching her chest. The care giver attempted to awakened the resident, who did not respond verbally or open her eyes or lift her head. The care giver encouraged Resident #3 to open her mouth and she spoon fed the medications to the resident. The resident was unable to assist with self-administering her own medications, she was unable to hold the spoon or bring the spoon/ cup to her mouth.
In an interview with the Administrator on at 11:15 AM she stated, Resident #3 required total assistance for all ADL care and was unable to assist to take her own medications. She stated, the health assessment was not an accurate reflection of the resident's present condition since the resident could not take her own medications and staff administered the medications. The Administrator stated, Resident #3 no longer met the admission criteria and therefore had been admitted to hospice services, she was not sure of the admission date.
Review of Resident #3's medical record indicated no documentation noting the resident's change in condition requiring admission to hospice services or a health provider order for the hospice evaluation. The last progress note in the record, dated on , indicated the resident was "doing good" and the resident had started physical .
In an additional interview with the Administrator on at 12:00 PM, she was requested to provide documentation of the hospice care being provided to Resident #3. The hospice documentation was received and a review of a health care provider order dated indicated a request for the hospice services evaluation, with a diagnosis of .
Review of the hospice admission summary for Resident #3 dated on , indicated Resident #3 was admitted

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

**0010** Continued From page 1

with the diagnosis of . The resident was assessed to be nonverbal, aphasic, legally , bed bound with overall and debility requiring total ADL care, having and bowel incontinence, increased difficulty swallowing with precautions, and history of multiple . The resident was assessed to have an unstageable on her right lateral foot and a on her left lateral lower leg. Review of the hospice nursing note dated on indicated Resident #3 had 3 wounds, a on the left lateral leg which was described as 3 x 3 cm, beefy red with no noted; a on the right outer foot which was described as gray/white, with no and a on the left medial inner foot which was described as hard black eschar with no . The note indicated care was to be conducted 3 times a week, to all three wounds consisting of cleansing with normal , apply ointment and cover with dry dressing. The note indicated that the hospice nurse had instructed the facility caregiver on dressing change procedures, signs of and when to notify the nurse.

In an observation on at 11:00 AM, the resident's (#3) three wounds were observed open with no dressing intact. The left lower leg was observed to measure approximately 2 x 2 cm open , reddened with no drainage noted. The left lateral foot was observed to be approximately 1 x 1 cm, a black darkened area with no drainage noted. The on the right foot lateral aspect was dry, crusted with no redness noted.

Further review of Resident #3's medical record indicated no documentation regarding the observation, assessment or monitoring of the wounds or any notification to the healthcare provider about the wounds.

In an additional interview with the Administrator on at 1:00 PM she stated, she recalled the podiatrist had visited Resident #3, date unknown, and a procedure was performed on Resident #3's right foot. The Administrator reviewed the medical record and could not provide any documentation of the visit. The Administrator stated, proper documentation of any changes in the resident ' s condition and observations should be noted in the resident ' s medical record.

2. Review of Resident #4's medical record indicated medical diagnoses including , ( ), and anorexia. The health assessment dated on indicated, the resident required assistance with her ADL care including eating and assistance with self-administration of her medications.

In an interview with the care giver on at 7:30 AM she stated, Resident #4 had numerous open wounds over her arms and legs and the resident was receiving daily care by the home health nurse.

In an observation of Resident #4 on at 8:15 AM, she was receiving AM care in the shower. Resident #4 was observed to have numerous dark bluish purple mottled areas on the anterior and areas of her arms and legs and she had several areas of dark purple/ blackish, fluid filled on the backs of her legs. The resident cried out when the care giver attempted to dry the resident's skin. Areas of the resident ' s lower extremities were observed to be wrapped in gauze and clear flexi dressings had been applied over the numerous purplish areas on her upper arms and legs.

In an additional observation of Resident #4 on at 9:20 AM she was observed sitting at the dining after finishing her breakfast, the resident was alert to name only. When the care giver informed her that she had morning medications to take, Resident #4 stated, "I didn't know I took medications." The care giver was observed to offer Resident #4's medications and the resident was observed to swallow the medications, with each medication, Resident #4 was observed to ask, the care giver, "what is that?"

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
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| TLC III | 8395 SW 112 STREET MIAMI, FL 33156 | |

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

**0010** Continued From page 2

In an interview with the Administrator on at 9:40 AM, she stated that Resident #4 was able to feed herself with staff assistance. She stated that the resident was unaware of her medications and reasons for the medications that she was prescribed. She stated that the health assessment was not an accurate reflection of the resident's present condition since the resident was unable to recall medications prescribed or reason for medication administration. The Administrator stated that Resident #4 had numerous wounds over her entire body and was being visited daily by the home health nurse for care treatments.

In an interview with the home health nurse on at 10:05 AM she stated, Resident #4 was diagnosed with a from an " response" after her recent transfer from out of state and progressive declining nutritional status. The nurse stated, Resident #4 was being seen weekly by a gerontologist, and her medications had been adjusted and care treatments prescribed. The nurse stated, she had been completing the skin treatments since , and the wounds appeared to be improving with the use of medication, care treatments and increased nutritional intake. She stated, Resident #4 was scheduled to go to the physician on for re-evaluation. The nurse stated, the wounds " began as areas of purplish mottled skin and then formed into a fluid filled " ," which turned black and then off, creating an open raw area." She stated, the resident does not have any of the /mottled skin on her trunk or , only on her upper and lower extremities.

During care observation conducted on at 10:10 AM the Resident (#4) complained often of very sensitive, tender painful skin when the nurse removed the dressings and performed care. When Resident #4 was asked by the nurse if she had pain, the resident denied having pain.

Review of the facility's medical record for Resident #4 indicated no documentation of the resident's and no documentation of any observations, monitoring, or care provided to the resident and no documentation of physician notification of the initial observations. In addition, review of the current health assessment indicated no required nursing interventions or treatments being provided the resident.

In an additional interview with the Administrator on at 11:00 AM she stated, Resident #4 had not been admitted with the " " and that "her skin was clear." She stated, the resident developed the "response" after she was admitted to the facility. The Administrator stated that she had notified the health care provider when the care givers observed the skin discoloration and development of the , but she had failed to document the notification. The Administrator stated, she will be re-evaluating the resident ' s appropriateness for continued admission at the facility to determine if the facility can meet the ongoing care needs of the resident.

3. Review of Resident #5's health assessment dated indicated the resident had medical diagnoses including advanced , , , , and . The resident is nonambulatory, required total assistance with all her activities of daily living (ADL), and required a pureed diet with thickened liquids with precautions. The assessment indicated Resident #5 required assistance with self-administration of her medications.

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

**0010** Continued From page 3

In an interview with the care giver on at 8:00 AM, she stated that Resident #5 was recently admitted to hospice services.
In an observation of Resident #5 on at 9:30 AM, during the breakfast meal, the resident was observed to asleep repeatedly, and the care giver would cue the resident to open her mouth, which allowed the care giver to feed the resident her breakfast. The resident was observed to slowly lean to her left side, causing her head to hang over the chair armrest, the care giver staff were observed to frequently repositioned the resident upright in the chair.
In an additional observation of Resident #5 on at 10:50 AM, the resident was asleep sitting in a recliner chair, leaning to her left side. When awakened by the care giver, the resident did not open her eyes or verbally respond. The care giver was observed to place Resident #5 ' s prescribed medications into paper cups, crushing the medications and mixing them into applesauce. The care giver then spoon fed the medications into Resident #5's mouth. The resident was unable to assist with self-administering her own medications, she was unable to hold the spoon or bring the spoon to her mouth.
Review of Resident #5's progress note dated , indicated the resident was " doing fine," "eating OK." No additional documentation was noted in the medical record regarding hospice services, physician notification of medical changes for the resident or the physician order for hospice evaluation.
In an interview with the Administrator on at 11:00 AM, she was requested to provide documentation of the hospice care being provided to Resident #5. The hospice documentation was received and a review of a health care provider order dated on indicated a request for the hospice services evaluation, with a diagnosis of .
Review of Resident #5's hospice admission assessment dated on indicated the resident was admitted with the diagnosis of . The resident was assessed to be nonverbal, aphasic, bed bound with overall and debility requiring total ADL care, having and bowel incontinence, increased difficulty swallowing with precautions, and as a result a history of weight loss.
In an additional interview with the Administrator on at 11:30 AM, she stated that Resident #5 was unable to feed herself and required total staff assistance for all ADL care. She stated, the resident was unaware of the medications she was prescribed and was unable to assist to take her own medications. She stated, the health assessment did not accurately reflect Resident #5's present condition since the resident could not take her own medications and did not indicate the resident was placed on hospice services.
Review of the facility's complaint investigation report from - and Directed Plan of Correction (DPOC) by the agency dated on indicated, the facility was directed to have a current complete health assessment for each resident and the medical record should contain documentation of all medical hospitalizations, significant changes in the resident's status and correspondence with all medical providers, and also any care services provided by the facility should be documented in the resident's record. Review of the facility's responsive plan dated / indicated, the " facility would obtain and maintain updated and complete health assessments for each resident. The plan indicated any changes to the resident's medical status must be recorded in the resident's record and should include all correspondence with medical and service providers, as well as documentation of any care services provided by the facility staff."
In an additional interview with the Administrator on at 3:45 PM, she stated that the residents ' medical records had not been updated to reflect the current care and services required for the residents and they lacked the required documentation of changes in residents medical status and the care services being provided for each

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

**0010** Continued From page 4

resident.

Uncorrected Class 2

**0053 - Medication - Administration - 58A-5.0185(4) FAC**

Based on observation, interview, and record review, the facility failed to ensure that unlicensed staff only provided assistance with self -administration of medications. The facility failed to have licensed personnel administer medications to 3 of 7 sampled residents, (Residents #3, #4 and #5).

The findings included:

1. Review of Resident # 3's medical record indicated medical diagnoses including advanced and nonambulatory. Resident # 3's health assessment dated indicated the resident required total assistance with all her activities of daily living (ADL) care including eating. The resident required a pureed diet with thickened liquids with precautions. The assessment indicated Resident #3 required assistance with self-administration of her medications.
In an observation of Resident #3 on at 9:50 AM, the resident was sitting in a wheelchair, she was asleep, her shoulders hunched over and her chin touching her chest. The care giver attempted to awakened the resident, who did not response verbally, open her eyes or lift her head. The care giver was observed to place Resident #3 ' s prescribed medication; into a paper cup then crushed the medication and mixed it into applesauce. The care giver encouraged Resident #3 to open her mouth and she spoon fed the medications to Resident #3, she also administered Geritrol solution. The resident did not lift her chin while swallowing the medications. The resident was unable to assist with self-administering her own medications, she was unable to hold the spoon or bring the spoon/ cup to her mouth. The caregiver did not inform the resident of the medications she was providing to the resident.
In an interview with the Administrator on at 11:05 AM she stated that Resident #3 was unable to feed herself and required staff to feed the resident all of her meals. She stated that the resident was unaware of her prescribed medications and was unable to assist to take her own medications. She stated that the health assessment was not an accurate reflection of the resident's present condition since the resident could not take her own medications.
2. Review of Resident #4's medical record indicated medical diagnoses including and anorexia. The health assessment dated indicated the resident required assistance with her ADL care including eating and assistance with self-administration of her medications.
In an observation of Resident #4 on at 9:20 AM, she was observed sitting at the dining , the resident was alert to name only. When the care giver informed her that she had morning medications to take, Resident #4 stated " I didn't know I took medications". The care giver was observed to place Resident #4's medications, including , and one at a time, into a paper cup, and Resident #4 swallowed the pills. The resident was observed to swallow liquid and Cerovite medication also. Resident #4 was observed to ask after each medication was provided, "what is that?"

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

**0053** Continued From page 5

In an interview with the Administrator on at 9:40 AM she stated that Resident #4 was able to feed herself with staff assistance. She stated that the resident was unaware of her prescribed medications and the reasons for the medications. She stated that the health assessment was not an accurate reflection of the resident's present condition since the resident was unable to understand the reason for the prescribed medications due to her .

3. Review of Resident #5's health assessment dated on indicated the resident had medical diagnoses including advanced and . The resident required total assistance with all her activities of daily living (ADL), and required a pureed diet with thickened liquids and precautions. The assessment indicated Resident #5 required assistance with self-administration of her medications.
In an observation of Resident #5 on at 10:50 AM, the resident was sitting in a recliner leaning to one side, asleep. When awakened by the care giver, the resident did not open her eyes and she did not respond verbally. The care giver was observed to place Resident #5 ' s prescribed medications including , D 3, and into paper cups, crushing the medications and mixing them into applesauce. The care giver spoon fed the medications to resident. The resident was unable to assist with self-administering her own medications, she was unable to hold the spoon or bring the spoon to her mouth. The caregiver did not inform the resident of the medications she was providing to the resident.
In an interview with the Administrator on at 11:05 AM she stated that Resident #5 was unable to feed herself and required total staff assistance for all of her meals. She stated that the resident was unaware of the medications she was prescribed and unable to assist to take her own medications. She stated that the health assessment was not an accurate reflection of the resident's present condition since the resident could not take her own medications.

Uncorrected Class III

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

Based on observation, record review, and interview, the facility failed to have documentation of a health care surrogate, guardian, or power of attorney for 1 of 7 (Resident #4) sampled residents.

The findings included:

Record review revealed that Resident #4's family member signed her entire admission record.
Record review on revealed that Resident #4 did not have documentation of having a health care surrogate, guardian, or the power of attorney on file for the family member.

On at 12:00 pm, the Administrator acknowledged that Resident #4 did not have documentation of having a hea surrogate, guardian, or the power of attorney on file for the family member.

Uncorrected Class III

# State Form: Revisit Report

**(Y1) Provider / Supplier / CLIA / Identification Number**
AL11965295

**(Y2) Multiple Construction**
A. Building
B. Wing

**(Y3) Date of Revisit**

**Name of Facility**
TLC III

**Street Address, City, State, Zip Code**
8395 SW 112 STREET
MIAMI, FL 33156

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **A0008**<br>Reg. # **429.26(4-6) FS; 58A-5.0181**<br>LSC | Correction Completed | ID Prefix **A0030**<br>Reg. # **58A-5.0182(6) FAC; 429.28**<br>LSC | Correction Completed | ID Prefix **A0056**<br>Reg. # **58A-5.0185(7) FAC**<br>LSC | Correction Completed |
| ID Prefix **A0077**<br>Reg. # **429.176 FS; 58A-5.019(1) F**<br>LSC | Correction Completed | ID Prefix **A0093**<br>Reg. # **58A-5.020(2) FAC**<br>LSC | Correction Completed | ID Prefix **A0165**<br>Reg. # **429.23(1-4 & 6-10) FS; 58A**<br>LSC | Correction Completed |
| ID Prefix **AZ827**<br>Reg. # **408.812, FS**<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
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| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

**Reviewed By State Agency** **Reviewed By** **Date:** **Signature of Surveyor:** **Date:**

**Reviewed By CMS RO** **Reviewed By** **Date:** **Signature of Surveyor:** **Date:**

**Followup to Survey Completed on:**

**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
lii
8395 Sw 112 Street
Miami, FL 33156

Dear Administrator:

This letter reports the findings of a Monitoring revisit survey conducted on , 2015 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

**All deficiencies shall be corrected no later than**

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. Should you have any questions please call this office at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

BBT7

Miami Field Office
8333 N.W. 53rd Street, Suite 300
Miami, FL 33166
Phone:(305) 593-3100; Fax:(305) 593-3121
AHCA.MyFlorida.com