STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965295	R 10/20/2016
NAME OF PROVIDER OR SUPPLIER TLC III	STREET ADDRESS, CITY, STATE, ZIP CODE 8395 SW 112 STREET MIAMI, FL 33156	

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

0000 Initial Comments

A Standard Survey Second Revisit was conducted on 10/2016. TLC III with standard license and license number 9762 had the following deficiencies identified found at the time of the survey:

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, the facility failed to limit physical to half bed rails and failed to have orders for bed rails and the signed consent for use for one out of three (#2) sampled residents.
Findings included:
During the facility tour on / at 8:50 A.M. observed in 6 which was occupied by Resident #2 (hospice resident) full bed rails attached to the bed.
During an interview on at 10:09 A.M. the facility Manager walked to # occupied by Resident #2 to see the full bed rail attached to her bed. She acknowledged that bed had full bed rail. She stated " I do not have the physician order."
Class III

0054 Medication - Records

Based on record review and interview, the facility failed to maintain daily medication observation record (MOR) for one out of three sampled residents (#3) who received assistance with self-administration of medications.
Founding included:
Record review showed the MOR for Resident #3's medication (Sol 10 GM/15 takes 30 ML orally every morning) was not initialed on at 8:00 A.M. by facility staff.
During an interview on with facility's manager and owner, both acknowledged the MOR was not initialed for Resident #2's medication on .
Class III

Z814 Background Screening Clearinghouse

Based on observation, record review, and interview, the facility failed to maintain or register employees in the clearinghouse.
Findings included:
Observation on / at 9:35 A.M. the facility's Manager arrived to the facility.
Review of the background screening website for providers showed that the facility did not register the Manager. Record review showed the Manager was hired on /.

AGENCY FOR HEALTH CARE ADMINISTRATION

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	AL11965295	R **10/20/2016**
NAME OF PROVIDER OR SUPPLIER **TLC III**	STREET ADDRESS, CITY, STATE, ZIP CODE **8395 SW 112 STREET** **MIAMI, FL 33156**	

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

In an interview on 1020/16 at 10:43 A.M. the facility's Manager and owner acknowledged after reviewing the clearinghouse roster that one staff did stopped working here for about six weeks and facility manager name was not listed there.
Unclassified

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11965295 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TLC III	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0010 Reg. # 429.26(1&9) FS; 58A-5.0181(4) FAC LSC	Correction Completed	ID Prefix A0077 Reg. # 429.176 FS; 58A-5.019(1) FAC LSC	Correction Completed	ID Prefix A0162 Reg. # 58A-5.024(3) FAC LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE 11/3/14	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 5/18/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: 4TJY13

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
lii
8395 Sw 112 Street
Miami, FL 33156

Dear Administrator:

This letter reports the findings of a **second** Standard Licensure Revisit Survey conducted on 20, 2016 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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

YOSF

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