STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953342	R 06/05/2017
NAME OF PROVIDER OR SUPPLIER **PROFESSIONAL HOME CARE III, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **447 EAST 26 STREET HIALEAH, FL 33013**	

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

0000 - Initial Comments

A standard biennial revisit survey was conducted on , 2017. Professional Home Care III, Inc. with limited mental health and limited nursing services components, license #94, had the following deficiency identified at the time of the survey:

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

Based on record review and interview, the Assisted Living Facility failed to ensure that residents meet the admission criteria for one (#14) out of 14 sampled residents.

Findings included:

Review of Resident #14's record revealed admission date was on . Health Assessment (AHCA form 1823) completed on showed medical history and diagnoses: , , No , gait imbalance, Chronic Kidney III, . Physical or sensory limitations: loss of balance, unsteady gait. or behavioral status, Nursing/ treatment/ service requirement: under hospice care. Assistance for all activities of daily living with clarification next to about hospice care.

Resident #14 also had an updated Health assessment (AHCA form 1823) completed on showing medical history and diagnoses: , , No , gait imbalance, Chronic Kidney III, . Physical or sensory limitations: loss of balance, unsteady gait. or behavioral status, Nursing/ treatment/ service requirement: under hospice care. Assistance for all activities of daily living with clarification next to about hospice care. Resident was bedridden with clarification next to of bed and chair bound status.

Resident #14 was admitted under hospice services on with diagnosis of with , , . Clinical review completed on showed that resident required total assistance with activities of daily living and have dependence with bathing, dressing, feeding, transfers, and toileting. Resident was chair bound. Under nursing summary showed that resident during the last 6 months has shown positive signs and symptoms of declined as evidenced by decreased , decreased appetite, functional decline, and decline, also showed that resident required 20 minutes to be fed per meal.

In an interview on at 1:05 PM the Staff Member A revealed that Resident #14 was able to walk

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with assistance and ate independently and Resident #14 did not receive hospice services at the time of admission.

Class III