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
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 An unannounced revisit to the Relicensure, Generator Monitoring and Complaint (2024003543) was conducted on at Sun Coast Residential Care Inc. The facility had uncorrected deficiencies related to the Relicensure, Generator Monitoring and Complaint at the time of the survey.	{A 000}		
{A 054}	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 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	{A 054}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 054}	Continued From page 1 429.41, 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 observation record review and interview, it was determined that, the facility failed to maintain a daily Medication Observation Record (MOR) for each resident receiving assistance with self-administration of medication or medication administratio, for 1 out of 1 sampled resident (Resident #1). The findings included: During a Medication Audit (medication review) conducted on this surveyor observed resident's medication available for review (Med Aduit). However, further review of the facility's records revealed no current MOR for available documenting that Resident #1 is receiving assistance with self-administration of medication or medication administration. During an interview on at approximately 10:30 AM the Administrator was informed to provide a plan of corrective action for the items mentioned above. At this time, he stated he is not able to provide documentation to support corrective action. The Administrator was unable to provide a MOR for to current for Resident #1. Class III Uncorrected	{A 054}		
{A 078}	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF.	{A 078}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 078}	Continued From page 2 (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record,	{A 078}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 078}	Continued From page 3	{A 078}		

and to report the observations to the resident's health care provider in accordance with this rule chapter.
(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.
(d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents.
(e) For facilities with a licensed capacity of 17 or more residents, the facility must:
1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,
2. Maintain time sheets for all staff.
(f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure staff had documented evidence of the annual negative ( ) for 2 of out 4 sampled Staff (Staff A and B).

The findings included:

Review of the facility's personnel file on Staff A (Administrator) with a hire date of . Staff A last negative annual date of .

Review of the facility's personnel file on Staff B (Caregiver) with a hire date of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 078}	Continued From page 4 . Staff B last negative annual date of . During an interview on at approximately 10:30 AM the Administrator was informed to provide a plan of corrective action for the items mentioned above. At this time, he stated he is not able to provide documentation to support corrective action. Therefore,the Administrator was unable to provide documentation indicating Staff A and B had documentation of a negative examination on file. Class III Uncorrected	{A 078}		
{A 080}	429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements. (3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics: (a) State law and rules relating to assisted living facilities.	{A 080}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 080}	Continued From page 5 (b) Resident rights and identifying and reporting , neglect, and , . (c) Special needs of elderly persons, persons with mental illness, and persons with , and how to meet those needs. (d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food. (e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. (f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures. (g) Care of persons with 's and related . 59A-36.011 (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to , , and managers who attended the core training program prior to , , , shall not be required to take the competency test. Administrators licensed as nursing home	{A 080}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 080}	Continued From page 6	{A 080}		

administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement.
(c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years.
(d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must:
1. Retake the assisted living facility core training; and,
2. Retake and pass the competency test.
(e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, it was determined that, the facility failed to ensure the Administrator had completed CORE training requirement of 12 hours of continuing education.

The findings include:

During a review of the Administrator's personnel file revealed CORE Training and Exam completion date of . Further review of the personnel file revealed the last training requirement of the 12 hours of continuing education was dated .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 080}	Continued From page 7 During an interview with the Administrator on at approximately 10:15 AM, he was informed to provide proof for the CORE Training continuing education for the year 2023. During an interview on at approximately 10:30 AM the Administrator was informed to provide a plan of corrective action for the items mentioned above. At this time, he stated he is not able to provide documentation to support corrective action. Therefore, the Administrator was unable to provide proof of compliance with the continuing education requirements. Class III Uncorrected	{A 080}		
{A 081}	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025.	{A 081}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 081}	Continued From page 8 However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:	{A 081}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 081}	Continued From page 9 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training.	{A 081}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 081}	Continued From page 10 (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to provide documented Elopement Drills conducted twice a year, the facility failed to ensure complete Preservice Orientation (Staff In-Service Training) the facility failed to ensure staff had complete training in Nutritional and Safe Food Handling for 2 of out 4 sampled staff (Staff A and B).	{A 081}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 081}	Continued From page 11 The findings include: 1)During review of the personnel file on for Staff B (Caregiver) with a hire date of revealed no documentation for Elopement drills for the year 2023. Further review of the file revealed no documentation of the Preservice Orientation and 1-hour training in Nutritional and Safe Food Handling in her file. During an interview with the Administrator on at approximately 10:15 AM he was informed to provide documentation for Elopement drills for the year 2023 and documentation of the Preservice Orientation for Staff B. The Administrator was asked if, Staff B prepares and serves food to the residents during her shift (breakfast and Dinner) and he stated yes. During an interview with the Administrator on at approximately 10:45 AM he stated he prepares and serves food to residents when Staff B is not available. 2) During review of the personnel file on for Staff A (Administrator) with a hire date of revealed no documentation for 1-hour training in Nutritional and Safe Food Handling in his file. During an interview on at approximately 10:30 AM the administrator was informed to provide a plan of corrective action for the items mentioned above. At this time, he stated he is not able to provide documentation to support corrective action. Class Uncorrected	{A 081}		

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
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 084}	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label;	{A 084}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 084}	Continued From page 13 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or	{A 084}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 084}	Continued From page 14 manipulation of the site; and, n. Measurement of , , rate, temperature, and , , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that staff who provide assistance with	{A 084}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 084}	Continued From page 15	{A 084}		

self-administration of medications had completed 2-hour continuing education training for assistance with self-administer medications for 2 out of 4 sampled staff (Staff A, and B).

The findings include:

During an interview with Staff A (Administrator) on at approximately 10:45 AM he stated he covers the weekend shift as live-in (24 hours) and he confirmed that he assists with self-administration of medications. The Administrator stated Staff B (Caregiver) assist with self-administration of medications Monday through Friday (Day Shift).

During a record review of Staff A on 11/09/2024 with a hire date of , it was revealed that Staff A had no documentation of the required 2-hour annual training assisting with self-administration of medications for the years 2023 and 2024. The last training documented in his file is dated . Further review revealed the initial 6-hour training was not in the personnel file at the time of the survey.

During a record review of Staff B on 11/09/2024 with a hire date of , it was revealed that Staff B had no documentation of the required 2-hour annual training assisting with self-administration of medications for the year 2024. The last training documented in her file is dated . Further review revealed the initial 6-hour training was not in her personnel file at the time of the survey.

During an interview on at approximately 10:30 AM the administrator was informed to provide a plan of corrective action for the items mentioned above. At this time, he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 084}	Continued From page 16 stated he is not able to provide documentation to support corrective action. Therefore, the Administrator was unable to provide proof of the medication training for Staff A and B. Record review confirmed, no corrective action. Class III	{A 084}		
{A 085}	59A-36.011(7) FAC Training - Nutrition & Food Service (7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that, the facility failed to ensure the Administrator, or designated person responsible for the facility's Food Service had completed annual continuing education for 1 out of 4 sample staff (Staff A) The findings include: During an interview with the Administrator on at approximately 10:45 AM, he stated	{A 085}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 085}	Continued From page 17 he is the facility's Food Service designee. The Administrator was informed to provide documentation for the Food Service continuing education. Review of the facility's personnel record on for Staff A (Administrator) with a hire date of revealed last documented continuing education for Nutrition and Food Service was dated . During an interview on at approximately 10:30 AM the administrator was informed to provide a plan of corrective action for the items mentioned above. At this time, he stated he is not able to provide documentation to support corrective action. Class III	{A 085}		
{A 120}	429.17(3) .275(1); 59A-36.013(1) FAC Fiscal - Financial Stability 429.17 (3) In addition to the requirements of part II of chapter 408, each facility must report to the agency any adverse court action concerning the facility's financial viability, within 7 days after its occurrence. The agency shall have access to books, records, and any other financial documents maintained by the facility to the extent necessary to determine the facility's financial stability. 429.275 (1) The administrator or owner of a facility shall maintain accurate business records that identify, summarize, and classify funds received and expenses disbursed and shall use written	{A 120}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 120}	Continued From page 18 accounting procedures and a recognized accounting system. 59A-36.013 Fiscal Standards. (1) FINANCIAL STABILITY. The facility must be administered on a sound financial basis in order to ensure adequate resources to meet resident needs pursuant to the requirements of chapter 408, part II, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. This Statute or Rule is not met as evidenced by: Based on interviews, observation and record review, it was determined that, the facility failed to ensure it was operating on a sound financial basis and maintaining financial stability. It was determined that the facility failed to have sufficient financial resources available to maintain the monthly payments for the facility generator and to make needed repairs. The findings include: During an interview with the Administrator on at approximately 10:00 AM, he stated the generator was repossessed. This surveyor requested to see where the designated area for the generator was located. At this time, the Administrator provided the exact location for observations. An observation revealed the generator was located on the patio of the house, as confirmed by the Administrator. The area was noted to be without the fixed generator, it had been removed. During an interview with the Administrator on at approximately 10:30 AM. He stated the generator was repossessed in early 2024 and he does not remember the exact date of the repossession. The Administrator was asked to	{A 120}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 120}	Continued From page 19 provide an explanation as to why the generator was repossessed. The Administrator stated there are two financial components that resulted in the generator repossession. He stated the following: A) $30,000 amount for the Generator Unit, with monthly payments of $500 for 18 months to the local generator supplier/company to be paid by the facility. B) An initial $5,000 down payment that was borrowed from a financial institution (Bank/third party) for the purchase of the generator. The Administrator stated that having to pay for the generator (supplier) monthly, third party financial institution (Bank) and the local city fire department for unresolve inspections had put him on financial strain, therefore not able to make those monthly payments as scheduled on his contract. During confidential interviews on and with the local fire department and generator supplier it was determined that the facility has past invoices and unresolved violations that yield to monetary resolution, as a result of the uncorrected violations. It was also confirmed as of the date of the survey that the violations have not been corrected by the facility. During record review on of the facility's annual Fire Inspection dated revealed the following violations: 1) Hallandale Beach - Construction or work without a permit. Possible unpermitted construction or alteration. Inspector Notes: Generator removal without permit. It was advised the generator company removed the generator due to non-payment: Violation found , Will be rechecked on or after , Violation not repaired.	{A 120}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 120}	Continued From page 20 2)Fire alarm system is required to have annual inspection: Violation found , Will be rechecked on or after , Violation not repaired. 3)Fire alarm system is in need of repair: Violation found , Will be rechecked on or after , Violation not repaired 4) Inspector Notes: Diaper not functioning properly: Violation found , Will be rechecked on or after , Violation not repaired. 5) Fire sprinkler system is required to have annual inspection: Violation found , Will be rechecked on or after , Violation not repaired. 6) Replace damaged, painted or corroded sprinkler heads: Violation found , Will be rechecked on or after , Violation not repaired. 7) Emergency power supply required: Violation found , Will be rechecked on or after , Violation not repaired. 8) Fire extinguishers need service or replacement: Violation found , Will be rechecked on or after , Violation not repaired. 9) truss sign required: Violation found , Will be rechecked on or after , Violation not repaired During a record review on of the facility's generator supplier notice revealed the following:	{A 120}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 120}	Continued From page 21 A) Invoice dated from the generator supplier with Bill To and Service To the facility's Administrator name and facility address. Total amount of $22, 267.31 / Paid $0.00 / Balance of $22,267.31 Past due. B) Letter (undated) from the generator supplier addressed to the Administrator (facility address) documented supplier had made several attempts to collect on past due amount of $22,267.31 and it was very important to get in touch with the supplier regarding balance or supplier will be forced to take further action. The undated letter was signed by the supplier's bookkeeper. C) An agreement letter dated , signed and dated by both parties (Administrator and generator supplier). The agreement letter documented the following. Balance due of $12,767.31 The following is a payment plan for the above balance due on your generator project. You agree to pay [Generator Company] the amount of $1500 per month until paid in full on the 18th of every month. During a further confidential interview, it was revealed the generator was installed in , the total cost of the generator and installation was $26,187.43. The facility made a down payment of $5237.40 plus an additional third-party financing payment of $9500 in 2022 (at the time of initial down payment). The facility stopped making payments in 2022 (last payment). The facility upon agreement in , with the generator company agreed to make monthly payments of $1500(for 18 months) to ensure final payment of the outstanding balance of $12,767.31 and to bring the account current due to delinquent status. The facility made a total of 3	{A 120}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 120}	Continued From page 22 monthly payments (total of $4500) per the agreement, no further payments received. The final balance due before repossession was $8267.31. The generator was repossessed in . During an interview on at approximately 10:30 AM the administrator was informed to provide a plan of corrective action for the items mentioned above. At this time, he stated he is not able to provide documentation to support corrective action. Therefore, the Administrator was unable to provide documentation regarding the facility's expeditures and payment status, including proof that all uttilities were current and all outstanding vendors were paid in full. Class II Uncorrected	{A 120}		
{A 152}	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings:	{A 152}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 152}	Continued From page 23 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure that existing structural systems and appurtenances are maintained in good working order. The facility failed to provide a safe living environment for all residents that reside at the facility. The findings include: During a review of the facility's record revealed that the annual Fire Inspection dated . Further review of the inspection report revealed prompt action required by the facility for the following 18 violations as follows: 1) Emergency preparedness plan required:	{A 152}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 152}	Continued From page 24 Violation found , Will be rechecked on or after , Violation not repaired. 2) Emergency preparedness drills need to be documented: Violation found , Will be rechecked on or after , Violation not repaired. 3) Fire alarm system is required to have annual inspection: Violation found , Will be rechecked on or after , Violation not repaired. 4) Provide copy of annual fire alarm system inspection report: Violation found , Will be rechecked on or after , Violation not repaired. 5) Fire alarm inspection tag must be properly posted: Violation found , Will be rechecked on or after , Violation not repaired. 6) Fire alarm system is in need of repair: Violation found , Will be rechecked on or after , Violation not repaired. 7) Inspector Notes: Diaper not functioning properly: Violation found , Will be rechecked on or after , Violation not repaired. 8) Fire sprinkler system is required to have annual inspection: Violation found , Will be rechecked on or after , Violation not repaired. 9) Annual inspection tag must be posted: Violation found , Will be rechecked on or after , Violation not repaired.	{A 152}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 152}	Continued From page 25 10) Provide annual inspection report: Violation found , Will be rechecked on or after , Violation not repaired. 11) Replace damaged, painted or corroded sprinkler heads: Violation found , Will be rechecked on or after , Violation not repaired. 12) Emergency power supply required: Violation found , Will be rechecked on or after , Violation not repaired. 13) Fire extinguishers need service or replacement: Violation found , Will be rechecked on or after , Violation not repaired. 14) Building address must be visible: Violation found , Will be rechecked on or after , Violation not repaired. 15) Update keys in Knox box: Violation found , Will be rechecked on or after , Violation not repaired. 16) Label keys in Knox box: Violation found , Will be rechecked on or after , Violation not repaired. 17) truss sign required: Violation found , Will be rechecked on or after , Violation not repaired. 18) Hallandale Beach - Construction or work without permit. Possible unpermitted construction or alteration. Inspector Notes: Generator removal without permit. Was advised the generator company removed the generator due to non payment: Violation found , Will be	{A 152}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 152}	Continued From page 26 rechecked on or after , Violation not repaired. During an interview on at approximately 10:30 AM the administrator was informed to provide a plan of corrective action for the items mentioned above. At this time, he stated he is not able to provide documentation to support corrective action. The Administrator had made no steps to correct prior identified physical plant concerns from the survey. Class III Uncorrected	{A 152}		
{A 162}	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C.	{A 162}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 162}	Continued From page 27 (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ◡ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ◡ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ◡ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S.	{A 162}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 162}	Continued From page 28 (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , , ( ), CF-ES 1006, ... , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a	{A 162}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 162}	Continued From page 29 resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview it was determined, the facility failed to maintain resident records on premises that include a copy of Health Assessment (AHCA Form1823), residents orders for medication, ⌄ record, copy of the resident contract, nursing services or other services to be provided, supervised or implemented by the facility that require a health care provider's order for 1 out of 1 sampled resident (Resident#1). The findings include: During a tour on between 10:00 AM and 2:00 PM this surveyor observed Resident #1 in his room. During an interview on at approximately 10:00 AM, Resident #1 stated, he is and depends on staff to assist with his daily personal care. During record review of Resident#1's file revealed an AHCA Form1823 documenting another facility's name. Further review of the chart revealed no documentation of Resident #1's orders for medication, ⌄ record, copy of the resident contract, nursing services or other services provided, supervised or implemented by the facility at the time of survey. During an	{A 162}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 162}	Continued From page 30 interview on at approximately 10:45 AM the Administrator was informed to provide copies of the above-mentioned documents. During an interview on at approximately 10:30 AM the administrator was informed to provide a plan of corrective action for the items mentioned above. At this time, he stated he is not able to provide documentation to support corrective action. Therefore, the Administrator was unable to provide proof that he had created a file for Resident #1 to include all of the required components as previous cited during the survey. Class III Uncorrected	{A 162}		
{A 200}	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the	{A 200}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 200}	Continued From page 31	{A 200}		

event of the loss of primary electrical power.
1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained.
2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code.
3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 200}	Continued From page 32 for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F. S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include	{A 200}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 200}	Continued From page 33 information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that	{A 200}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 200}	Continued From page 34 undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within 30 days of the approval of the plan from the county emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . , have implemented the plan	{A 200}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 200}	Continued From page 35 required under this rule. (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the	{A 200}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 200}	Continued From page 36	{A 200}		

written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request.
(c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law.
(6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines.
(7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN.
(a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule.
(b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan.
(8) NOTIFICATION.
(a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has

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
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 200}	Continued From page 37	{A 200}		

been granted, each resident and the resident's legal representative:
1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval;
2. Upon final implementation of the plan by the assisted living facility.
3. Annual submissions and approvals of the plan do not require notification to residents or their legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan.
(b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure their Emergency Environmental Control Plan (EECP) was up-to-date and approved by the Broward County Emergency Management Division.

The findings include:

Review of the facility Emergency Environmental Control Plan (EECP) file provided on , revealed missing notification of the EECP letter approval.

A review of the Local County Emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST RESIDENTIAL CARE INC	813 SW 9TH STREET HALLANDALE BEACH, FL 33009

(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 200}	Continued From page 38 Management Division's database on documents EECP status as under review. Further review revealed no entries or information documenting that the facility had submitted the request for an approval of their EECP. The facility was also unable to provide any information regarding their EECP. During an interview on at approximately 10:30 AM, the Administrator was informed to provide documentation of the EECP approval Plan, either in electronic or paper format, at this time the Administrator stated due to a repossession of the fixed generator in early 2024 (unable to provide date of the repossession) he stated EECP approval is pending. The Administrator was asked if he had reported the changes to the Local County Emergency Management Division and he stated no. He stated due to outstanding violations from the local Fire Department was unable to move forward with submission until all violations are cleared. The Administrator stated, the facility is now operating off a portable generator. During an interview on at approximately 10:30 AM, the administrator was informed to provide a plan of corrective action for the items mentioned above. At this time, he stated he is not able to provide documentation to support corrective action. Therefore, the Administrator was unable to provide documentation of the EECP compliance requirements with the local Emergency Management Division. Class III Uncorrected	{A 200}		