STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965505	08/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Sun Coast Residential Care	813 Sw 9th Street Hallandale Beach, FL 33009	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D
St - A - 0080 - 58a-5.0191(1) Fac - Training - Core & Competency Test S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced Relicensure survey with the Limited Nursing Services survey was conducted on . . . . . at Sun Coast Residential Care, Inc. The facility had deficiencies found at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on observation,interview and record review, the facility failed to ensure resident records accurately reflect the current health status/condition and care needs for 1 out of 3 sampled residents (Resident #2) . As evidenced by lack of documentation for the assessment, monitoring and follow-up with the physician about weight loss for Resident # 2.

The findings include:

Resident #2 was admitted on with medical diagnosis of congential deformities and right BKA. His admission weight was 85 pounds. The Resident Health Assessment Form (AHCA Form 1823) dated reveals the resident is alert, ambulates with crutches. He has a history of and requires assistance with ambulating and bathing. He is independent for eating and on a regular diet. He requires assistance with medication management.

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During a review of the record for Resident #2, it was revealed the resident had a weight loss of 8 pounds, specifically with weight for : [redacted] of 88; [redacted] of 85; [redacted] of 83; [redacted] of 82 and [redacted] of 80.

An interview was conducted with the aide on [redacted] at approximately 12:00 PM during which she was asked if the Physician was notified that the resident was experiencing weight loss. The aide responded that the resident had a physician's order for nutritional supplements and was receiving Boost High Protein 1 can twice daily. She stated the resident consumed the supplement. Review of the Medication Observation Records from [redacted] until present reveal the resident has received the supplement as ordered. The aide stated that the resident has fair appetite and ambulates to the dining [redacted] every meal. An observation of the resident on [redacted] at 12 noon meal noted, the resident consumed 25-50% of his meal, and 100% of the supplement drink.

Review of the medical record reveals no progress notes by the facility staff documenting weight loss, interventions implemented or notification to the physician about the weight loss.

On [redacted] at approximately 2:30PM during an interview with the Administrator, he stated that the resident is seen by the physician but could not provide any documentation of visits, and any further weight loss prevention interventions. He stated that he personally weighs the resident and was aware the resident continued to lose weight. He stated he had not called the physician about the weight loss.

Class III

0054-Medication - Records 58A-5.0185(5) FAC

Based on observation, interview and record review, the facility failed to maintain an accurate daily medication observation record (MOR) for a resident. As evidenced by facility failure to accurately document medications prescribed by the physician on the MOR, for 1 of 3 sampled residents (Resident #1).

The findings include:

Record review for Resident #1 revealed the resident was admitted on [redacted]. The resident has medical diagnoses including with left [redacted] history of multiple [redacted] with left [redacted] is,and enlarged [redacted] Review of the Resident Health Assessment form completed [redacted] reveals the

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resident was assessed to be independent for most ADL care but requires assistance with self administration of his medications. Further view reveals the resident is on numerous medications throughout the day.

On at approximately 12:00 PM during an interview with the Administrator, he stated that the resident did not have a MOR since the resident was self administering his medications from a pill box, from which the Administrator had been refilling weekly. He reviewed the current Resident Health Assessment form and confirmed the facility should have been assisting the resident with self administration and completing a MOR. He confirmed that he was ALF Core trained and recently had completed annual update training on assistance with medication management but was not aware he could not refill the pill box.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and interview,the facility failed to properly secure prescribed medications. As evidenced by facility failure to store medication in a secure location at all times.

The findings include:

On at 8:30AM, the medication file cabinet was observed open with the lock removed and the latch open. Five prefilled pharmacy cards with medications for Resident # 2 were observed resting on top of the kitchen counter.

On at approximately 9:30AM, an interview was conducted with the aide who assists residents with self administration of their medications; she confirmed that the medications should be locked and secured at all times. She acknowledged that the residents at the facility are mobile and have access to the kitchen area.

Further observations conducted during the entire survey on revealed the medication cabinet was left open and the keys left on the kitchen counter. On at 2:00 PM, a resident was observed in the kitchen area, he picked up and moved the keys aside, and then started to prepare his food.

On at 3:00 PM during an interview with the Administrator, he acknowledged that the

medications should be secured at all times.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on observation, interview and record review the facility failed to properly administer prescription medications. As evidenced by the failure to dispense medications from properly labeled containers, for 1 of 3 sampled residents (Resident #1).

The findings include:

On [redacted] at approximately 11:00 AM during an observation of medication storage for the facility, the surveyor inquired about the medications for the resident. The aide provided a weekly pill organizer and bag of prescription pill bottles for the resident. She stated that the resident takes his own medications from the pill organizer and the Administrator fills the pill organizer every week. She stated that she assists the other residents their self administration of medications.

During further medication reconciliation, the surveyor observed pill organizer with 3 orange oval shaped tablets, in the "evening" compartment, inside the pill organizer. When the aide was asked for the prescription medication bottle for the tablets, she provided a bottle labeled [redacted] 40 mg by mouth, 1 every day. The tablets description was white and round. Eight (8) orange oval tablets were observed inside the bottle, along with a red/ maroon capsule. The Administrator was interviewed to confirm observations and he acknowledged that the tablets were placed in the incorrect bottle. The aide stated that the tablets were actually [redacted] 15 mg, which the resident is prescribed 3 tablets at bedtime. She stated that she had emptied the tablets into the [redacted] bottle and threw away the original [redacted] bottle. The Administrator returned to provide the original bottle that he removed from the garbage. The Administrator could not locate the Medication Observation Record for review, as requested.

Record review of a " Assistance with Self Administration training certificate" with the aide's name reveals a completion date, 2 contact hour training, on [redacted] Further interview with the Administrator on [redacted] at approximately 3:00 PM, he acknowledged the failure to follow accepted standards of pharmacy practice and stated the aide would need to complete the course again. He stated

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he was not aware of the situation until surveyor observation.

Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC

Based on observation, interview and record review, the facility failed to ensure that the posted written work schedule was accurate.

The findings are:

Observations on at approximately 8:30 AM, found an aide in the facility caring for residents at time of entrance. Three residents were observed in the facility at that time.

Record review of the facility Staffing Schedule for 2014 revealed the aide was scheduled to work from 6PM until 8AM and the Assistant Administrator to relieve her at 8 AM The Administrator was scheduled to work on from 10PM to 8 AM. The staffing hours could not be accurately The Administrator was not at the facility at time of entrance, but arrived at the facility at approximately 9:15 AM. One additional name was listed on the schedule to work 10AM to 4pm, but she was not at the facility.

In an interview was conducted with the facility Administrator on at approximately 3:00 PM, he stated that he is attempting to hire additional staff and he has been covering the facility on most days. Furthermore, he stated that the employee listed on the schedule was recently hired, and has not completed orientation or background screening.

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0080-Training - Core & Competency Test 58A-5.0191(1) FAC

Based on interview and record review, the facility failed to maintain core training requirements for the Administrator. As evidenced by the facility failure to provide documentation the Administrator had completed the required 12 hours continuing education training every 2 years.

The findings include:

On at approximately 2:00 PM during employee record review, the surveyor was unable to locate the required documentation of the 12 hours of continuing education training every 2 years for the Administrator. During an interview with the Administrator, the surveyor requested documentation of the core continuing education training within the last two years. The Administrator reviewed his file but was unable to locate documentation of required continuing education.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC

Based on observation and interview, the facility failed to ensure foods were stored at safe temperatures. As evidenced by staff cooking food too far in advance and allowing it to sit on a turned-off stove top. This has the potential to affect all four current residents of the facility.

The findings include:

During the review of the facility's kitchen food service operations conducted , the following concern was observed:

At 8:30AM the surveyor observed the lunch entree, baked fish with tomatoes and onions and rice with peas and carrots cooking on the stove top. At 10:30 AM, the stove was observed to be turned off and the pans cool, the fish and rice was still on the stove. On at approximately 11:15 AM during an interview with the aide she stated that she works nights and prepares the noon meal before she leaves the facility in the morning.

This observation was brought to the facility Administrator's attention, he acknowledged the food should not be left on a turned-off stove and should have been refrigerated after cooking, or prepared closer to the resident's lunch time. The fish and rice was observed to be reheated prior to lunch meal at 12:15 PM.

Class III

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0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC

Based on observations and interviews, the facility failed to provide a safe , sanitary living environment free from hazards.

The findings include:

During a tour of the facility with the Administrator on at 10:00 AM, the following was noted.

1. The resident , middle hallway , the main light switch not working, no light in Chipped paint inside shower area. Privacy in shower was missing slates, allowing vision to outside/ building next door. Toilet seat paint chipped.

2. The resident , nearest the kitchen, wall paper peeling and holes in wall around toilet area. Paint chipped in tub/shower stall area. Toilet seat loose, missing screws.

3. The resident , middle front hallway, opaque window above tub/shower, broken glass, large pieces missing with jagged edges. Privacy missing slates allowing vision to outside.

4. Resident next to kitchen, observed wasp nest in corner near ceiling, blinds missing from outside window. Sheer curtains allowing vision into . Resident states blinds were torn down by another resident one year ago.

5. Dining soiled cushions on chairs. Floor tiles and grout soiled. Dust/ dirt on curtains above resident dining tables. A/C intake vent near dining with accumulated dust and dirt.

6. Kitchen floor broken tiles around oven and sink area. Soiled floor with dried food and dirt. Broken cabinet door from sink cabinet leaning up against cabinet. Corner wall edge near stove is chipped, water damaged.

7. Outside walkway accessing the building, tiles are broken and pieces missing, causing a trip hazard for residents.

8. Walls throughout facility are soiled and paint chipped. Light switches are soiled and tacky to touch.

9. Medication cabinet lock has loose screws.

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The Administrator was interviewed on at 2:00 PM and confirmed the findings.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Sun Coast Residential Care
813 SW 9th Street
Hallandale Beach, FL 33009

Dear Administrator:

This letter reports the findings of a state licensure survey with Limited Nursing Services (LNS) that was conducted on , 2014 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within ***thirty days*** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State form 5000-3547
XG90

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