STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922235	08/18/2015
NAME OF PROVIDER OR SUPPLIER **SUN COAST**	STREET ADDRESS, CITY, STATE, ZIP CODE **9111 SW 28 TERRACE** **MIAMI, FL 33165**	

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

0000 Initial Comments

A limited nursing services monitoring survey was conducted on , 2015. Sun Coast with Limited Nursing Services component had the following deficiencies found at time of survey:

0030 Resident Care - Rights & Facility Procedures

Based on record review and interview, the Assisted Living Facility failed to have a doctor order for the use of half-bed rail reviewed annually by the resident's physician for one (#1) out of one sampled residents.

Findings included:

Record review of Resident #1's file revealed that Resident #1 had a doctor order for half-bed rail signed on . The facility did not have a doctor's order for half bed rails for Resident #1.

In an interview with the Administrator on at 1:46 PM revealed that she did not know that this resident #1's doctor order for the use of half-bed rails was expired.

Class III

0078 Staffing Standards - Staff

Based on record review and interview, the Assisted Living Facility's Registered Nurse failed to have evidence of a negative examination documented on an annual basis.

Findings included:

Record review of Registered Nurse's personnel file revealed that the nurse's last examination was on . The facility failed to have a negative examination documented on an annual basis for the nurse.

In an interview with the Administrator on at 1:46 p.m. revealed that her physical examination was expired because her doctor was in vacation.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Sun Coast
9111 Sw 28 Terrace
Miami, FL 33165

Dear Administrator:

This letter reports the findings of a limited nursing services montoring survey that was conducted on , 2015 by representative(s) 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

XG90

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