STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967463	11/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COAST LOVING CARE INC	**5517 HAYES STREET HOLLYWOOD, FL 33021**

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

0000 - Initial Comments

An unannounced abbreviated re-licensure survey was conducted on 11/29/2016 at Gold Coast Loving Touch, Inc. Licence#11493. The facility had a deficiency at the time of the visit.

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to safely store medications and properly dispose of medications after a resident has been discharged.

The findings Include:

a) On / at approximately 9:45AM, the facilities storage was observed, it revealed Resident#1's was stored in the facility's primary food refrigerator. The medications were as follows: Bottle #1- R 100 Units Filled: / / and Expired / . Bottle#2 R 100 Units, Filled: / and Expired: / . The medication was stored in the left side of the inside door bin of the refrigerator. The medication was in it's pharmacy package and was not in a separate locked container. The refrigerator is the primary refrigerator for the facility and contains food and other refrigerated items. The medicating was stored in a location that was openly accessible to the residents in the facility.

During an interview with the Administrator at approximately 10:00AM, she acknowledged the findings and stated she was not aware that she needed to store the medication in a separate locked container and/or in a secure manner.

b) On / at approximately 9:50AM, during observation of the facility's storage, it revealed two vials of R 100 units. Bottle#1 was filled and Expired on . Further review revealed Bottle#2 vial of R 100 units filled and opened with an expiration date of / . A review of Resident#1's Medication Observation Record (MOR) were consistent with the medication label. The medication was stored in location that was openly accessible to all residents in the facility.

During an interview with the Demonstrator, she stated because she does not administer the medication she was not aware it was expired. She stated she would return to pharmacy.

c) On / at approximately 9:55AM, during the storage observation, revealed a vial of medication 1000 mcg/ml. Label Inject 1 ML subquetaneously everyday for 5 days, then 1 ML every week for 3 weeks, then every month for 6 months. Further review of the medication label

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revealed the medication had an expiration date of 3/ / . Further review of the facility's Admission and Discharge Log revealed Resident#5 was discharged from the facility on / / (47 days) to the hospital and will not be returning to the facility.

During an interview with the Administrator at approximately 11:10AM, she stated she did not realize the medication was in the refrigerator. The administrator stated she did not contact the family after the medication was left at the facility. She acknowledged the findings and provided no additional information for review.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Gold Coast Loving Care Inc
5517 Hayes Street
Hollywood, FL 33021

RE: Monitoring Visit

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 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. **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 , 2016.** 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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