STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967463	**01/11/2018**
NAME OF PROVIDER OR SUPPLIER **GOLD COAST LOVING CARE INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **5517 HAYES STREET** **HOLLYWOOD, FL 33021**	

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

0000 - Initial Comments

A monitoring inspection was conducted on at Gold Coast Loving Care, Inc. (License #11493). Gold Coast Loving Care had deficiencies found during this visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to have completed the resident health assessment for 1 out of 2 sampled residents (resident #4).

The findings are:

Review of resident #4 health assessment dated on indicated that the resident did not have any diagnosis, and she needed assistance with her activities of daily living (ADLs), including eating, toileting, transfers, dressing and . Review of this health assessment indicated that the physician did not comment to the extent and type of ADL assistance or the level of medication assistance the resident needed to receive from the facility staff members. Further review of this health assessment indicated that the resident was bedridden, had , 3 or 4 pressure sores and required 24-hour nursing or , care.

In an interview with the administrator on at 1:10pm, she stated that the health assessment for resident #4 was not completed accurately and she did not consult with resident #4's physician to ensure it was completed.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review and interview, the facility failed to exercise the rights and facility procedures for 2 out of 2 sampled residents (residents #3 and 4) by not ensuring that the residents' bed rails were reviewed by their respective physician annually.

The findings are:

In an observation on 1-11--18 at 12:55pm, residents #3 and 4's beds were equipped with bed rails.

Review of resident #3's record indicated that the resident received a hospice plan of care revision dated on in which the physician requested that the resident use a full bed side rail for safety. Further review of the resident record indicated that there was no more recent physician review for the resident's

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use of bed rails.

Review of resident #4's record indicated that the resident received a hospice plan of care revision dated on and there were no specific physician orders relating to the resident's use of bed rails. Further review of the resident record indicated that there was no other physician reviews for the resident's use of bed rails.

In an interview with the administrator on at 1:05pm, she stated that residents #3 and 4 received hospice services, chose to use their bed rails and could not remove the bed rails without assistance. She stated that the facility did not ensure that the most recent physician reviews for residents #3 and 4 use of bed rails was completed and available for review.

Class III