AGENCY FOR HEALTH CARE ADMINISTRATION

PRINTED: 09/26/2018
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922235	**09/06/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN COAST	**9111 SW 28 TERRACE** **MIAMI, FL 33165**

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

0000 - Initial Comments

A Standard Biennial Survey in conjunction with limited nursing services monitoring survey was conducted on , 2018 and concluded on , 2018. Sun Coast (AL#7958) with Limited Nursing Services component had the following deficiencies identified at the time of the survey:

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

Based on record review and interview, the Assisted Living Facility failed to have Medication Observation Records (MORs) that included resident's , the name of the resident's health care provider, the health care provider's telephone number and directions for use of each medication for two out of six sampled residents (#1 and #6). The facility failed to immediately update the MORs each time the medications was offered or administered for one out of six sampled residents (#1).

Findings included:

Review of Resident #1's MORs showed the ' section had NKA (No Known). The medications were scheduled at AM and PM. There was an order for 0.5 mg and it was scheduled for PM. The facility did not sign the MOR for from thru . , , , and did not have directions for use.

On at 12:30 PM the Administrator revealed Resident #1 has been taking at bedtime but she forgot to sign it.

On at 7:52 AM, there were two white pills in a plastic disposable cup, three red, white and blue pills in a plastic disposable cup, a box of Azotp 1% ophth susp, a box of 0.005% opthsoln, a bottle of 600 mg and a bottle of Extra Strength Rapid Release at the top of night table in Resident #6's night table.

Review of Resident #6's MORs showed , the physician's name and telephone's sections were blank. The medications were scheduled at AM and PM. , , , , , , , , , , and Sinvastatin did not have directions for use. Staff initialed the MORs for Azotp 1% ophth susp from to , the morning and afternoon doses and morning dose on . Staff initialed the MORs for 0.005% opthsoln from to . The MORs did not include 600 mg and Extra Strength Rapid Release ,

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Review of Resident #6's record showed the health assessment dated . . . . . showed that the resident needed help taking her medications but it did not show what kind of assistance.

On . . . . . at 10:44 AM the Administrator revealed the facility assisted the resident (#6) with self-administration of medication.

On at 1:36 PM the Administrator revealed the residents took medications around 8 AM but staff can start at 7:30 AM. No medications were giving before 7:00 AM. Residents took medications and in the afternoon between 6:30 PM and 7:00 PM.

Class III

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

Based on observation, record review, and interview, the Assisted Living Facility failed to keep medications lock at all times for residents who receive assistance with self-administration of medications from unlicensed staff.

Findings included:

On . . . . . at 7:52 AM, there were two white pills in a plastic disposable cup, three red, white and blue pills in a plastic disposable cup, a box of Azotp 1% ophth susp, a box of , 0.005% opthsoln, a bottle of . . . . 600 mg and a bottle of Extra Strength Rapid Release . . . . . at the top of night table in Resident #6's night table.

Review of Resident #6's record showed that the health assessment completed on . . . . . It showed that the resident needed help taking her medications but it did not show what kind of assistance.

On . . . . . at 10:44 AM the administrator revealed that the facility assisted the resident (#6) with self-administration of medication.

Class III

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

Based on observation, interview, and record review, the Assisted Living Facility failed to maintain an accurate written work schedule that reflects its 24-hour staffing pattern.

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Findings included:

On at 7:48 AM Staff B was on duty with 6 residents. On at 8:07 AM the Administrator arrived.

On at 8:08 AM the Administrator apologized and reported she stepped out to take a family member to the school.

Review of staffing schedule showed that Staff B was a live-in. Staff B worked Tuesdays, Wednesday, Thursdays and Fridays 24 hours each day. The Administrator worked Tuesdays, Wednesday, Thursdays and Fridays from 7 AM to 10 AM and from 3 PM to 7 PM. Staff C worked Mondays, Saturday and Sunday from 7 AM to 10 AM and from 3 PM to 7 PM. Staff D worked Mondays, Saturday and Sunday 24 hours each day.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that unlicensed staff members who provide assistance with the self-administration of medications met the training requirements for three out of four sampled staff (Staff B, C, and D).

Findings included:

Review of Staff B, C, and D's records showed the last 2 hours of medication training was dated .

Review of Administrator's personnel record showed she was a Registered Nurse.

On at 1:38 PM the Administrator revealed that topic covered were:
- uncovered the medication bottle and take it out.
- checked that the resident takes the medicines.
- at scheduled times.
- gives water to the resident when taking the medication.
- Staff was able to assist the resident with .

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0085 - Training - Nutrition & Food Service - 58A-5.0191(7) FAC

Based on observation, record review and interview, the Assisted Living Facility failed to ensure that staff designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service obtain, annually, a minimum of 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility for three out or four sampled staff (Administrator, Staff B and Staff D).

Findings included:

On at 10:23 AM Staff B was in the kitchen preparing lunch. She prepared ground beef, white rice and beans.

Review of staffing schedule showed that Staff B was a live-in. Staff B worked Tuesdays, Wednesday, Thursdays and Fridays 24 hours each day. The administrator worked Tuesdays, Wednesday, Thursdays and Fridays from 7 AM to 10 AM and from 3 PM to 7 PM. Staff C worked Mondays, Saturday and Sunday from 7 AM to 10 AM and from 3 PM to 7 PM. Staff D worked Mondays, Saturday and Sunday 24 hours each day.

Review of Administrator's personnel record showed that she received the food and nutrition training on .

Review of Staff B's personnel record showed that she received the food and nutrition training on .

Review of Staff D's personnel record showed that she received the food and nutrition training on .

On at 9:47 AM the Administrated stated, "My daughter is a nutritionist. I don't have nutrition training. I thought it was every 2 years."

Class III

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

Based on record review and interview, the Assisted Living Facility failed to date and plan the menu at least 1 week in advance.

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Findings included:

Menu posted in the bulletin board on [redacted] at 7:50 AM was for the week of [redacted] to [redacted].

On [redacted] at 12:10 PM the facility posted the new menu [redacted] at [redacted].

On [redacted] at 1:55 PM, the Administrator was asked about the menu but she did not answer.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review, interview and observation, the Assisted Living Facility failed to have an accurate health assessment for one out of six sampled residents (#4). The facility did not have an updated weight log for one out of six sampled residents (#4). The facility failed to have a completed health assessment for two out of six sampled residents (#1 and #6).

Findings included:

Review of Resident #1's health assessment revealed it was not completed or dated.

Review of Resident #4's last health assessment completed on [redacted] showed a medical history and diagnoses of: [redacted], and HPL ([redacted]). It did not document the resident received hospice services. The resident needed total care for all activities of daily living. It showed the resident was not bedbound, it did not have a [redacted] information or medication assistance needed.

Review of Resident #4's hospice record showed that admission date to hospice was on [redacted] with diagnosis of [redacted] and [redacted] in other [redacted] classified elsewhere. Last plan of care was on [redacted]. It showed the resident was bedbound, contracted time 4 (upper and lower extremities). Resident had a [redacted] in the sacrum 1 x 0.5 and 100% granulated.

On [redacted] at 11:07 AM, the Administrator revealed she administered the medications to the resident. The resident was bedbound and had a [redacted] in the sacrum.

On [redacted] at 11:22 AM, the hospice nurse revealed that the resident had a [redacted] in the sacrum and it was [redacted] on healing process. The onset was before [redacted] 2016.

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Review of Resident #4's weight log showed that the last note was on . . . . . 2015. It showed that the resident was bedbound and unable to weigh.

Review of Resident #6's record showed that the health assessment completed on . It showed that the resident needed help taking her medications but it did not show what kind of assistance.

On . . . . . at 10:44 AM the administrator revealed that the facility assisted the resident with self-administration of medication.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on observation, record review, and interview, the Assisted Living Facility failed to acquire and maintain a monoxide alarm. The facility failed to notify in writing to each resident and the resident's legal representative that the emergency power plan was submitted, approved and implemented. The facility also failed to maintain fuel as required at all times when the assisted living facility is occupied.

Findings included:

1. On . . . . . at 7:48 AM during the tour to the facility, there was not a . . . . monoxide alarm in the facility.

On at 8:38 AM the Administrator revealed that the facility does not have the monoxide detector.

2. There was no evidence in the facility that each resident or the resident's legal representative was notified that the emergency power plan was submitted, approved and implemented.

On at 8:39 AM the Administrator revealed that she explained to residents the previous year when everything started but the facility have provided to resident/resident representative the written notification of the plan.

3. Facility implemented the emergency power plan on .

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On at 8:32 AM, there was no fuel in the facility for the operation of the generator. Facility had the containers but they were empty.

On at 8:32 AM, the Administrator revealed that she will pick up fuel to any of the gas stations closed to the facility. There was a local ordinance that facility was not allow to store fuel (gasoline) in the facility. The administrator will ensure to have gas for keeping the generator working for at least 96 hours.

On at 8:32 AM the Administrator revealed that facility will keep fuel in the shelter behind the facility that is more than 10 feet away.

Class III