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	AL11965505	**09/04/2018**
NAME OF PROVIDER OR SUPPLIER **SUN COAST RESIDENTIAL CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **813 SW 9TH STREET** **HALLANDALE BEACH, FL 33009**	

SUMMARY STATEMENT OF DEFICIENCIES
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0000 - Initial Comments

An unannounced Relicensure survey was conducted on [redacted] at Sun Coast Residential Care, License #9856. The facility had deficiencies at the time of the visit.

The above Relicensure survey was conducted in conjunction with licensure complaint survey CCR #2018011787. Please see separate report for findings.

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

Based on record review, observations, and interview, the facility failed to ensure the Resident Health Assessment form (AHCA 1823 form) was completed within 30 days of admission into the facility and ensure that the form addresses all of the residents current care needs for 2 of 4 sampled residents residing at the facility (Residents #2 and Resident #3).

The findings included:

a) Review of the file on [redacted] for Resident #2 revealed no AHCA 1823 form, physician orders or progress notes observed in the residents file. Review of the residents demographic sheet revealed that the resident was admitted into the facility on [redacted]. During an interview with Resident #2 at 12:00 PM, it was revealed that the resident is visually [redacted] and need assistance with all activities of daily living (ADL's). Review of the file revealed no documentation that reflects Resident #2's current condition or anything that reflects his current care needs.

b) Review of the file and the AHCA 1823 form for Resident #3 dated for [redacted] revealed that Resident #3, admitted to the facility on [redacted] is independent with all ADL's and has a medical history and diagnosis of Unspecific [redacted], weight loss, tobacco use, [redacted] and a unspecific hypertrophic condition of the skin. Interview with Resident #3 on [redacted] revealed that the resident is visually [redacted] and needs assistance with all ADL's except eating.

During an interview with the Administrator at 2:00 PM on [redacted] it was stated that he the thought the form for Resident #2 was in the file and that he doesn't know what happened to it. It was further stated that he will get a new one for Resident #3. During this time the findings were discussed and acknowledged by the Administrator. No further documentation was provided for review during this time.

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Class III

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

Based on record review and observation, the facility failed to sign the Medication Observation Record (MOR), immediately after assisting with self-administration of medication, for 2 of 3 sampled residents (Resident #2 and Resident #3).

The findings Included:

Random review of the MORs for the month of [redacted] 2018 at 10:00 AM on [redacted] revealed that the MORs had not been signed off on any of the residents (Resident #2 & #3) for the months of [redacted] or [redacted]. During an interview with the Administrator at 10:00 AM on [redacted], it was stated that it is his fault and that he hasn't been marking them off but they have been getting their medicine.

Further review of the MORs on [redacted] revealed that the MORs for [redacted] was not in the medication book. During an additional interview with the Administrator at 12:22 PM on [redacted] it was stated the MORs for [redacted] is not here for Resident #2 and Resident #3 and that he will look for them. When the Administrator opened the locked medication cabinet observations revealed that the medication cabinet had multiple medications from residents that no longer live at the facility. During an interview regarding the medication storage It was stated at 12:27 PM on [redacted] that usually the Pharmacy comes and picks it up when they deliver the new medications every month, but I forgot to put them out this month. After searching for 10 minutes through the medication drawers, the MORs for [redacted] were found still in the packaging in which the pharmacy delivered it. The Administrator put the MORs in the medication book. During this time, the findings were discussed and acknowledged, no further information was provided for review during this time.

Class III

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

Based on observation and interview, the facility failed to dispose of expired medication in a timely manner.

The findings included:

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Further review of the MORs on revealed that the MORs for 2018 was not in the medication book. During an additional interview with the Administrator at 12:22 PM on it was stated the MORs for is not here and that he will look for them.

Observations of the Administrator opening the locked medication cabinet while looking for the Medication Observation Records (MORs) for the month of revealed that the medication cabinet had multiple medications from residents that no longer live at the facility.

During an interview regarding the medication storage It was stated at 12:27 PM on that usually the Pharmacy comes and picks it up when they deliver the new medications every month, but I forgot to put them out this month. During this time the findings were discussed and acknowledged with the Administrator, no additional information was provided for review.

Class III

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

Based on observation, record review and interview, the facility failed to ensure that prescriptions for residents who receive assistance with self-administration of medication are filled or refilled in a timely manner for all residents residing that the facility (Resident#1, Resident #2, and Resident #3).

The findings included:

While waiting to observe a 12:00 PM medication pass at 1:33 PM on with the Administrator, Surveyor intervention revealed that Resident #3 had never received his eye drops and now the medication is considered overdue. It was stated by the Administrator during this time that I don't have the eyedrops the pharmacy never sent it.

At 2:00 PM on , an audit of the medication drawer was conducted for Residents #1, Resident #2, and Resident #3. Resident #2 was observed to be missing eyedrops and Ointment that is to be applied to the affected area daily at 8:00 AM. During an interview with the Administrator at 2:10 PM it was stated that the ointment is kept in the residents . Upon request to observe the ointment, the Administrator brought one that when reviewed stated Bacterium. Review of the Medication Observation Record (MOR) and review of the medication tube provided revealed that the medication provided by the Administrator was not the same medication that was listed on the MOR. Further review of Resident #2 medications revealed that the eye drops 0.005% was not there.

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During an additional interview at 2:15 PM on . . . . . with the Administrator, it was stated that he does not have any eye drops in the facility for any of the residents. At 2:19 PM the Administrator contacted the Pharmacy to find out the reasons the medications was not delivered and for Residents. The findings were discussed and acknowledged, no further information was provided for review.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observation, interview and record review, it was determined the facility failed to ensure that each staff member had evidence of a negative . . . . . examination documented on an annual basis, for 1 of 11 sampled staff records (Staff A).

The Findings Include:

During an Employee Record Review of Staff A's file hire date and Staff B's file hire date . . . . . on . . . . . revealed that that there was no evidence of a negative . . . . . examination or communicable . . . statement documented from a licensed healthcare provider.

During an interview with the Administrator on . . . . . and 4:32 PM the findings were discussed and acknowledged. The Administrator was given the opportunity to locate the documentation, no additional documents were provided for review

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

Based on Observation, Record Review, and Interview the facility failed to ensure that all staff who provide direct care to residents received all of the required 1-hour in-service trainings within 30 days of employment.

The findings included:

Employee Record review of the file for Unlicensed Staff (Staff A) hire date . . . . , revealed that the following 30 day 1-hour in-service trainings were not in the file:

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1. Elopement response training
2. Emergency preparedness & Evacuation training
3. Incident reporting training
4. Recognizing/ Reporting , Neglect & , training
5. Control Training
6. ADL and Behavioral Needs Training (3 hours)
7. Training
8. Resident rights training
9. P & P training

During an interview with the Administrator on and 4:32 PM the findings were discussed and acknowledged. The Administrator was given the opportunity to locate the documentation , no additional documents were provided for review

Class III

0082 - Training - / - 58A-5.0191(4) FAC

Based on Observation, Record Review, and Interview the facility failed to ensure that all staff who provide direct care to residents received all of the required in-service training in / within 30 days of employment.

The findings included:

Employee Record review of the file for Staff A (hire date), revealed no documentation of / training within 30 days of employement into the facility. During an interview with the Administrator on and 4:32 PM the findings were discussed and acknowledged. The Administrator was given the opportunity to locate the documentation, no additional documents were provided for review

Class III

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

Based on observation, record review and interview, the facility failed to ensure the facility's dietician approved menu was followed at all times as evidenced by not serving or substituting items of comparable nutritional value for menu items

The findings included:

Observations of dining at 12:30 PM on revealed a lady from {pizza location #2} delivering two boxes of pizza to the facility that was ordered by the Administrator. Upon preparing the meal, the Administrator gave each resident 2 slices of pepperoni and pineapple pizza with a cup of juice.

Upon coming to the dining for lunch, Resident #2 began eating the meal and stated this pizza is really good and asked the Administrator is this place you usually order from? The Administrator stated no, that place is called {pizza location #2 name }, this pizza is from {pizza location #2 name}.

Review of the menu for the day revealed that meat loaf and gravy, mashed potatoes, green peas, a dinner roll/bread, and applesauce with cinnamon was to be served. The pizza prepared and served to the residents was not of comparable nutritional value with the items listed to be served on the dietician approved menu. No vegetables were served or a comparable amount of protein.

During an interview with the Administrator at at 3:40 PM the findings were discussed and acknowledged for the dietary issues identified throughout the survey, no further information was provided for review during this time.

Class III

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

Based on observation, and staff interview the facility failed to provide a safe, clean living environment, free of hazards and ensure that all existing structural systems are maintained in good working order for 3 of 3 residents (Resident #1, Resident #2, and Resident #3) residing at the facility.

The findings included:

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Tour and observations of the facility on . . . . . between the times of 10:00 AM and 11:00 AM revealed the following:

a) Observations of the outside of the facility revealed a sign that stated "Ring Buzzer for attention" observations of the wall revealed in writing the word "Busser" no actual buzzer was observed to allow entrance into the facility.

b) . . . . . - located inside of . . . . . revealed a hole in the wall that exposed the wood underneath. The hole was located on the wall adjacent to the shower on the right side. During an interview with the Administrator upon arrival at 10:15 AM revealed that the two residents in the . . . . . uses that that both residents are and requires assistance with all of their ADL's. The whole in the wall pose a safety hazard for the two residents. Further observations of the . . . . . two holes underneath the grab bar. The toilet tissue fixture was moved to a different location on the wall and the holes from where it was previously located was still there. Additional observations of the wall and the grab bar adjacent to the toilet tissue fixture revealed a brown matter resembling feces observed on the wall, and on the grab bar

c) . . . . . located in the hall revealed dirt and dust on the tile floor along the bottom area of the walk-in shower. Observations of the inside of the shower revealed a grimy matter that resembled dirt in the crevices between the tiles on the shower floor.

d) Observations of the light fixtures in the . . . . . rust around each of the three light bulbs. Observations of the towel track revealed the middle piece that holds the towel was missing, and the two end pieces that connects to the wall was still there.

e) . . . . . located in the hall way adjacent on the right of . . . . . revealed a rusted light fixture that held three light bulbs. Of 3, only 1 lightbulb was observed.

f) - the largest the facility was observed to have a rusted light fixture. Out of three light spots that the fixture holds only 2 bulbs were observed, and of the two only 1 was working.

g) Observations of the air conditioning vents throughout the facility was observed to have large clumps of dust and black spots. Further observations of the vents revealed a black matter of tiny spots on the covering of the vent that resembles mildew.

h) Observations of the kitchen revealed a pile of dirty dishes observed on both side of the sink piled high. Observations of the double door fridge revealed brown spots and brown stains all over the bottom

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half of both doors of the refrigerator. Observations of the tiled floor on in the kitchen revealed cracked tiles in various places and a hole from the cracked tile in the middle of the kitchen floor, posing a hazard for anyone walking in the kitchen without shoes on, or anyone that may have a rolling walker.

Observations of the table (The Trap door) that lifts up that separates the dining the kitchen revealed the wood on the wall that holds the table piece up was loose when touched.

Observations of the ceiling in the hallway revealed multiple cracks in the ceiling observed by the light bulb. Observations of the cracked ceiling revealed a yellow sponge like material coming out of one of the cracks.

At 4:00 PM on the physical plant findings were discussed and acknowledged with the Administrator. No further information was provided for review.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on interview and record review, the facility failed to have a Comprehensive Emergency Management Plan (CEMP) approved by the local emergency management agency.

The findings included:

Upon request of documentation from the local Emergency Management Division of an approved CEMP for the year 2018 through 2019 on no current documentation was provided.

During an interview with the Admin at 11:00 AM on it was stated that this is the last one I have, and that I recently just got the environmental control plan in . Review of the last CEMP approval letter was dated for in which it was approved up until of 2018 from the local emergency management division.

During this time The Administrator acknowledged that the facility does not have a CEMP approval letter. No further information was provided at this time.

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on observation, record review and interview, the facility failed to ensure that all persons that has access to the residents' personal property and living areas had a background screening (BGS) completed.

The findings included:

The Surveyor arrived at the facility at 9:45 AM on and was greeted by someone the name of "Confidential" at the facility's front gate. The gate was locked, and "Confidential" asked who was the Surveyor and that the Administrator was not here at the facility and that she would call him. The Surveyor showed the state ID badge in which "Confidential" than went inside the facility to go get the phone and gate code leaving the Surveyor standing outside of the gate unable to get into the facility.

Upon entrance to the facility at 9:55 AM it was asked to "Confidential" what is her last name and her title at the facility. "Confidential" stated that she does not work at the facility and that she is just a visitor that comes every few weeks. When asked is there any staff here working, it was stated "yes The Administrator." The Surveyor stated that the Administrator is not here, is anyone else here that is working? it was stated no, and that the Administrator will be here soon.

While waiting for the Administrator to arrive at 9:57 AM "Confidential" was observed sweeping the floor in the kitchen and providing assistance to Resident #2 who was calling "Confidential" by name from the . When "Confidential" came back from providing the assistance it was asked a second time to "Confidential" that she did state that was a visitor? "Confidential" confirmed by stating "yes." It was further asked "do the Administrator leave you here often alone with no one here?" It was stated no, and that I'm not here often, I stop by to visit a resident here once every few weeks. When asked, do you always clean and help the residents when you are here to visit? It was stated "sometimes."

At 10:08 AM the Administrator arrived at the facility. During an interview with the Administrator at 10:18 AM on when asked why did you leave your residents alone with a visitor and there's no staff here? it was stated that he had to go pick up tires for his truck.

Review of the BGS website on revealed that "Confidential" did not have a background screening, or a file at the facility.

During an interview with the Administrator at 4:32 PM the findings were discussed and acknowledged. No further information was provided for review.

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Unclassified