STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965505	**02/18/2019**
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
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced licensure complaint survey, CCR #2018016813 was conducted on and at Sun Coast Residential Care, License #9856. The facility had deficiencies identified at the time of the survey.

(This survey was conducted in conjunction with the Relicensure revisit on the same date. See separate report for findings.)

0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC

Based on observation, interview, and record review, the facility failed to ensure the safety and supervision of it's residents for 1 of 4 residents (Resident #2) residing at the facility. As evidenced by leaving a visually resident that requires assistance with all Activity's of Daily Living (ADL's) unattended in the hot sun for an extended period of time.

The findings included:

Upon entrance to the facility at 9:34 AM on , Resident #2 was observed sitting out in the sun smoking a cigarette by himself with no staff observed outside. Observations of the resident revealed that the resident kept his closed while smoking the cigarette, and had no place nearby to put the ashes holding the cigarette away from his body for the ashes to on the ground. During an interview with Resident #2, at this time, it was stated that the Staff allow him to come outside after meals and smoke a cigarette, and come out to get him when he is finished. The resident further stated that he has to wait on staff to go inside because the staff assist him with everything and that he is and cannot see.

At 10:34 AM, Resident #2 was still observed outside in the sun with no observations of the staff checking on the resident within the 1 hour time frame that passed by. Surveyor Intervention requested Staff A to check on Resident #2 as the resident was left outside smoking a cigarette in the hot sun with no staff present to supervise the resident in the case of an emergency or if the resident needs any assistance while sitting outside. Staff A brought Resident #2 inside the facility. Observations of the resident revealed that the residents was sweating and that his skin was very warm when touched. Staff A offered no beverage to the resident after being left out in the sun for so long.

Review of Resident #2's file revealed the resident requires assistance and supervision with all ADLs. The resident is also noted to be in the right . However, interview with the resident on

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revealed the resident is in both .

During an interview with the Administrator and Staff A at 4:00 PM on , concerns were expressed that the facility left a visually , resident alone outside to smoke a cigarette with no place to put the ashes or the cigarette when finished smoking. The resident is unaware of his surroundings and flick the cigarette anywhere away from himself not knowing if someone may be next to him or a flammable item nearby. The facility also left the resident outside unsupervised in hot temperatures for extended periods of time with no way to get inside or call the staff when needed. During this time the findings were acknowledged, and no further information was provided for review during this time.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation and interview, the facility failed to ensure that each resident is treated with consideration, respect, and with due recognition of personal dignity, for 1 of 4 sampled residents residing at the facility (Resident #4).

The findings included:

Observations of the facility's refrigerator revealed a lock was placed on the door handles of the refrigerator and freezer preventing the doors from opening and closing restricting access to food inside to only the staff working at the facility.

During an interview with the Administrator and Staff A at 4:00 PM on it was stated that Resident #4 gets up at night and goes in there and eat all the food that is inside, and that he does it all night and every night. It was further stated that the staff does not leave snacks available for the resident at night or offer the resident snacks at bed time for when he gets up during the night and that the staff put a lock on the refrigerator to stop him from going in there eating up all of the food.

Upon request, the facility could not provide any documentation that stated that residents are not allowed to eat after designated meal times set fourth by the facility. Review of the AHCA 1823 Health Assessment form for Resident #4 revealed no dietary restrictions preventing the resident from being able to eat outside of designated meal times. The facility did not ask the resident if he felt hunger after

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eating dinner or offered to provide any solution to satisfy the residents hunger after meal times.

The facility failed to put a policy and procedure in place to accommodate residents' that expresses hunger after meal times and restricted the food access to all residents residing at the facility making access to all meals and snacks unavailable until a staff member with a key is available to unlock the refrigerator door. The findings were discussed and acknowledged with Administrator and Staff A. No further information was provided for review during this time.

Class III

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, failed to ensure that the residents' nutritional needs are met by offering a variety of meals adapted to the food habits, preferences. This was evidenced by not serving or substituting items of comparable nutritional value for menu items, and not having a sufficient 3-day emergency food supply based on census.

The findings included:

Observations of dining at 12:30 PM on revealed that Staff A prepared and served peas and rice (mixed), sautéed chicken, and a beverage choice of juice or milk. Review of the menu signed by the licensed dietician revealed that the menu posted on the facility's refrigerator door revealed a date for that stated week 1. The facility uses 4-week menu cycles that is to be rotated weekly. of the weeks from until revealed that the facility was due to use the menu for week cycle 3.

During an interview with Staff A on at 12:35 PM, it was stated that when I cook the meals I cook what is here or what the Administrator tells me to make. It was further stated that he came 2 days ago and have not went grocery shopping yet.

Request for the most current menu to review was provided by the Administrator at 12:40 PM. The Administrator handed the surveyor all 4 week cycles of menus. When asked what menu cycle is the facility on? The Administrator stated "Week 2." Review of the menu for week 2 revealed that the facility was to serve the following:
4 oz of tossed salad/, Baked Ham, Scalloped potatoes, Dinner Roll/Bread/Margarine, Broccoli,

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Apple Sauce with cinnamon, 6 oz Coffee/tea/beverage, 8 oz milk.

The menu for the day was substituted and the residents were not made aware prior. No green leafy vegetable was provided for substitution for the salad, or the broccoli. No bread roll of any kind was provided. No apple sauce or any dessert of any kind was provided. The menu substitution was not of equal comparable nutritious value for the residents at the facility, and the residents was not offered an alternative if the food items served was not of the residents liking.

During an interview with the Administrator on at 12:53 PM regarding the meal served for lunch it was stated that I just got . . . on Sunday and I did not go grocery shopping yet. I was gone from the week of , and that my wife usually does the grocery shopping here when I'm gone.

Observations of the facility's pantry with Staff A and the Administrator at 3:00 PM revealed no edible food items except for onions, cereal, and oatmeal. Observations of the facility's refrigerator revealed left over peas and rice in a container from lunch, uncooked chicken in a container undated, 2 slices of bologna meat. Further observations revealed 1 gallon of juice and 1 gallon of milk with enough liquid in each container to provide 1 cup of liquid to only 1 resident. There is a total of 4 residents residing inside the facility on the date of the survey. No other food or drink items were observed to nourish the residents in the event of , or hunger. Observations of the facility's freezer revealed 4 and a half sandwich bags of frozen chicken and a yellow container of liquid unidentified, uncovered, and undated. No other food items were observed.

Observations of the facility's emergency food supply revealed the following: 3 cans of cooked pasta with meat, 4 cans of tomato sauce, 3 containers of pasta, 2 cans of butter beans, pancake mix, and 1 can of beets. No observations of liquids, vegetables, or a sufficient number of food items to make 3 meals each day for 3 days for all 4 residents residing inside of the facility.

Review of the substitution log for the past 6 months revealed on multiple occasions items such as split , soup was substituted for "Ramen noodle Soup" and that Turkey sandwiches were substituted for "hotdog sandwiches."
During an interview with the Administrator at 4:09 PM on . The findings were discussed and acknowledged, no further information was provided for review.

Class III