Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments	A 000		

An Assisted Living Facility standard biennial licensure survey with limited nursing services was conducted on . . . . . Sun Coast Resident Care Inc. had licensure deficiencies found at the time of the visit.

A 008 SS=D	58A-5.0181(2) FAC Admissions - Health Assessment	A 008		

(2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection.
(a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following:
1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations;
2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living;
3. Any nursing or . . . . services required by the individual;
4. Any special diet required by the individual;
5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication;
6. Whether the individual has signs or symptoms of a communicable . . . . . which is likely to be transmitted to other residents or staff;
7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual ' s needs can be met in an assisted living facility; and
8. The date of the examination, and the name, signature, address, phone number, and license

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 008	Continued From page 1	A 008		

number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state.
(b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, ... 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows:
1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment.
a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion.
b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider.
c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided.
2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 008	Continued From page 2	A 008		

elements in Section 3. This requirement does not apply for residents receiving:
a. Extended congregate care (ECC) services in facilities holding an ECC license;
b. Services under community living support plans in facilities holding limited mental health licenses;
c. Medicaid assistive care services; and
d. Medicaid waiver services.
(c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823.
(d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).
(e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule.
(f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a order for residents who do not wish to be administered in the case of or
(g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 008	Continued From page 3	A 008		

415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission.

This Statute or Rule is not met as evidenced by:
Based on interview and record review, the facility failed to obtain the required medical examination (AHCA Form 1823) within the required timeframe upon admission to the facility for 1 out of 5 sampled residents (Resident #4).

The findings include:

Record review revealed Resident #4 was admitted to the facility on . . . . . Further review of his records revealed no documentation showing a medical examination (AHCA Form 1823) dated either six months prior to or within 30 days of his admission. In an interview conducted . . . . . at 11:55 AM, the facility's administrator stated they had not yet received the required form.

Class III

A 010 SS=D	58A-5.0181(4) FAC Admissions - Continued Residency	A 010	

(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 4	A 010		

criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement.
(a) The resident may be bedridden for up to 7 consecutive days.
(b) A resident requiring care of a pressure may be retained provided that:
1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a licensed health care provider, or the resident contracts directly with a licensed home health agency or a nurse to provide care;
2. The condition is documented in the resident's record; and
3. If the resident's condition fails to improve within 30 days, as documented by a licensed health care provider, the resident shall be discharged from the facility.
(c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 5	A 010		

2. Continued residency is agreeable to the resident and the facility;
3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility ' s license and total help with the activities of daily living; and
4. Documentation of the requirements of this paragraph is maintained in the resident ' s file.
(d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility.
(e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C.
(5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident ' s needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S.

This Statute or Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to follow the requirements for continued residency. Specifically, failure to obtain a medical examination after 3 years for a resident residing in the facility for 1 out of 5 sampled residents (Resident #1).

The findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 6 Record review revealed Resident #1 was admitted to the facility on . Further review revealed the only 1823 Health Assessment form available for review was dated . No updated assessment form was noted in the medical record during the survey. On : at approximately 10:00 AM during an interview with the Administrator she stated that she was aware that the 1823 Health Assessment form was outdated after 3 years and needed to be completed. She was unable to provide an updated 1823 form during the survey. Class III	A 010		
A 030 SS=D	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 7	A 030		

telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
(d) The statewide toll-free telephone number of the Florida Hotline " 1(800)9€ or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 8	A 030		

telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical [illegible] shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical [illegible]

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from [illegible] and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 9	A 030		

(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a [illegible] his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [illegible] the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 10	A 030		

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

This Statute or Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to maintain resident rights of respect and personal dignity as evidenced by the failure to allow 1 out of 5 sampled residents (Resident #2), the right to refuse medication by crushing his prescribed medications and inserting them into his food without his knowledge.

The findings include:

Record review for Resident #2 revealed he was admitted to the facility on . . . . . with diagnoses of left sided . . . . . accident with gait ataxia and . The current 1823 Health Assessment form dated , documented the resident's and behavioral status as being normal. The resident requires supervision for ambulation,bathing and toileting and he is independent for dressing, eating and self care. The form documents the resident as requiring assistance with self administering of medications. The resident is documented as independent for

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 11	A 030		

handling personal and financial affairs. Further record review reveals the resident signed his admission contract. The record contains no documentation the resident is and unable to make his wishes known.

On at approximately 10:30 AM during an interview with the resident he stated that he takes no medications.

On at 10:40 AM during record review of the 2012 Medication Observation Record (MOR), the record reveals the resident is documented as being administered the following medications:

daily from 9/1 until

On at approximately 10:45 AM during an interview with the Administrator, she reviewed the 2012 MOR and confirmed she had administered the prescribed medications to the resident. The surveyor informed her of the resident interview and she stated that the resident refuses to take his medications. Therefore, she crushes the medications and mixes them into his food. When questioned by the surveyor, who ordered the medications to be delivered this way, she stated that the family agreed to this method of administration. She could not provide any written documentation from the family requesting this method. The Administrator stated that she had informed the physician but did not have orders or an updated 1823 Health Assessment form documenting this method of administration for the resident. When questioned if the resident had been deemed and unable to make his own decisions, the Administrator stated she did not have any documentation reflecting a change in mental status.

Class III

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 12	A 054		
A 054 SS=D	58A-5.0185(5) FAC Medication - Records	A 054		

(5) MEDICATION RECORDS.
(a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the directions for use.
(b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known , the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered.
(c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication.

This Statute or Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to follow acceptable standards of practice regarding medication administration and documentation as evidenced by the failure to maintain an accurate medication observation record for 1 out of 5 sampled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 13	A 054		

residents (Resident #2).

The findings include:

Record review of the 1823 Health Assessment, completed on documents resident #2 as normal, he has a history of left accident with gait ataxia. The resident is independent with eating and requires a high protein diet. The resident was seen on by his physician who documents the resident as having a history of weight loss and being underweight. The physician lists active medications as suspension, an appetite stimulant and prenatal with daily as well as other medications for

Review of the 2012 Medication Observation Record (MOR) for the resident reveals the resident is documented as receiving prenatal every day from 9/1 until Also the MOR documents the resident receiving Ensure High Protein shake 1 can, three times a day from 9/1 until

Review of the medications for the resident reveals the facility did not have a supply of prenatal or Ensure available, as documented on the MOR.The supply of medications included only the suspension as ordered by the physician.

On at approximately 10:00 AM during an interview with the Administrator, she reviewed the resident's medication supply and 2012 MOR. She confirmed that no prenatal or Ensure was available for the resident. She stated that she has been documenting on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 14	A 054		

MOR that the resident received the medication/supplement but she was not administering them to the resident. She stated that the Ensure was expensive and she did not purchase it. She was unable to provide a physician order discontinuing both the items.

Class III

A 055 SS=D 58A-5.0185(6) FAC Medication - Storage and Disposal — A 055

(6) MEDICATION STORAGE AND DISPOSAL.
(a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises; or in their [illegible] or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if:
1. The facility administers the medication;
2. The resident requests central storage. The facility shall maintain a list of all medications being stored pursuant to such a request;
3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;
4. The resident fails to maintain the medication in a safe manner as described in this paragraph;
5. The facility determines that because of physical arrangements and the conditions or habits of residents, the personal possession of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 055	Continued From page 15	A 055		

medication by a resident poses a safety hazard to other residents; or
6. The facility ' s rules and regulations require central storage of medication and that policy has been provided to the resident prior to admission as required under Rule 58A-5.0181, F.A.C.
(b) Centrally stored medications must be:
1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked;
3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and
4. Kept separately from the medications of other residents and properly closed or sealed.
(c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident ' s representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident ' s request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked " discontinued medication. " Such medication may be reused if re-prescribed by the resident ' s health care provider.
(d) When a resident ' s stay in the facility has ended, the administrator shall return all medications to the resident, the resident ' s

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 055	Continued From page 16	A 055		

family, or the resident ' s guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident ' s medications are still at the facility, the medications shall be considered abandoned and may disposed of in accordance with paragraph (e).
(e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall be documented in the resident ' s record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.
(f) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on observation, interviews and record review, the facility failed to properly store and dispose of resident medications for 1 out of 5 sampled residents (Resident #1 and #2) as evidenced by failure to properly dispose of expired medications and allowing storage of over-the-counter medications in a community

The findings include:

1. Upon observation during the tour conducted on at 9:30 AM, the surveyor observed 2 bottles of medication in a bag inside the kitchen refrigerator. The bag contained 1 opened bottle of , which had an expiration date of and an opened bottle of MiAcid solution, labeled with Resident #1's name and prescribed dosage. The label indicated the MiAcid was prescribed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 055	Continued From page 17 ' and had an expiration date of . On ' at approximately 9:35 AM during an interview with the Administrator, she stated that she was unaware that the bottles were in the refrigerator. She confirmed the expiration dates on the bottles and stated she would immediately discard them. She stated that the resident was not prescribed the medication at this time. 2. The following concerns were noted during a tour of the facility conducted beginning at 9:55 AM while accompanied by the facility's manager. In the primary resident ' off the living stored on an open shelf over the sink were two packages of supplies and a container of jelly. In an interview conducted at that time, the manager stated the supplies belonged to current or prior residents of the facility and removed the items from the . Class III	A 055		
A 078 SS=D	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on a examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable including . Freedom from must be documented on an annual basis. A person with a positive test must submit a health care provider ' s statement that the person does not constitute a risk of communicating . Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in	A 078		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 078	Continued From page 18	A 078		

service. If any staff member is later found to have, or is suspected of having, a communicable . he/she shall be removed from duties until the administrator determines that such condition no longer exists.
(b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff shall exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s health care provider in accordance with this rule chapter.
(c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C.
(d) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor shall specifically describe the services the staffing agency or contractor will be providing to residents.
(e) For facilities with a licensed capacity of 17 or more residents, the facility shall:
1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and
2. Maintain time sheets for all staff.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure staff provided required health statements for 3 out of 3 sampled employee files (Employee #1, #2 and #3), evidenced by lack of adequate and/or timely health provider

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 078	Continued From page 19	A 078		

statements related to freedom from signs and symptoms of .

The findings include:

Review of the personnel records on revealed the following concerns:

1. Employee #1 was hired Her file contained related health information dated more than a year prior to the survey. This information should have been dated either six months prior to or within 30 days of the employee's hire, and a new statement is required annually.

2. Employee #2 was hired Her file contained related health information dated more than a year prior to the survey; there was no documentation showing an examination provided by a health care provider (MD, PA, ARNP or DO).

3. Employee #3 was hired His file contained related health information dated more than two years prior to the survey; a new statement is required annually.

These findings were discussed with and acknowledged by the facility's administrator on at 4:37 PM.

Class III

A 090 SS=D	58A-5.0191(11) FAC Training - Do Not Orders	A 090	

(11)
TRAINING.
(a) Currently employed facility administrators,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 090	Continued From page 20	A 090		

managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policies and procedures regarding _____ within 60 days after the effective date of this rule.
(b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policy and procedures regarding _____ within 30 days after employment.
(c) Training shall consist of the information included in Rule 58A-5.0186, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure staff who provide direct care to residents received required training in _____ RO's) for 2 out of 3 sampled employee files (Employee #1 and #2).

The findings include:

Review of personnel files for employee #1 and #2 was conducted _____ No documentation was located showing they received the required one hour of training within 30 days of hire, including the following:

1. Form SCHS-4-2006 Health Care Directives, the Patient's Right to Decide, or a significantly similar document

2. The facility's policy and procedures related to RO's

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 090	Continued From page 21 3. Information on how to obtain DH Form 1896, Florida , per 58A-5.0186 FAC (the gold-colored form) These findings were discussed with and acknowledged by the facility's administrator on at 4:37 M. He acknowledged these concerns, confirmed both employees provide direct care to the facility's resident and confirmed both employees have been employed at the facility more than 30 days. Class III	A 090		
A 092 SS=D	58A-5.020(1) FAC Food Service - General Responsibilities Food Service Standards. (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator or a person designated in writing by the administrator shall: (a) Be responsible for total food services and the day to day supervision of food services staff. (b) Perform his/her duties in a safe and sanitary manner. (c) Provide regular meals which meet the nutritional needs of residents, and therapeutic diets as ordered by the resident ' s health care provider for resident ' s who require special diets. (d) Maintain the in-service and continuing education requirements specified in Rule 58A-5.0191, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food service operations were	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 092	Continued From page 22	A 092		

performed in a safe and sanitary manner, evidenced by improper food storage and sanitation practices. This has the potential to affect all five current residents of the facility.

The findings include:

During the review of the facility's kitchen food service operations conducted [redacted] beginning at 11:35 AM with the facility's manager present, the following concerns were noted:

1. The refrigerator contained:
- A snack size container of applesauce, its contents were expanded and leaked out on the sides and the shelf, and was sticking to shelf of the refrigerator door
- Three partially-filled cups with red-colored drink on a shelf in refrigerator door not labeled and dated
- An open can of evaporated milk that was not dated or sealed, food debris was noted on the lid and sides of the can
- Three packages of foods were not dated and/or sealed properly

2. The dry storage cabinet contained:
- A moldy sweet potato and several moldy red potatoes
- A can of roach pesticide spray was stored on the same shelf as loaves of bread, and was touching containers of dry foods

3. The area to the right of the stove, especially the floor, and the wall from the floor to the ceiling were excessively soiled. The stove hood was excessively soiled.

These concerns were discussed with and acknowledged by the manager on [redacted] at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 092	Continued From page 23 11:40 AM. Class III	A 092		
A 093 SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, ... and activity, shall be the nutritional standard used to evaluate meals. Therapeutic diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA Assisted Living Program. (b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident daily by the facility are as follows: 1. Protein: 6 ounces or 2 or more servings; 2. Vegetables: 3 5 servings; 3. Fruit: 2 4 or more servings; 4. Bread and starches: 6 11 or more servings; 5. Milk or milk equivalent: 2 servings; 6. Fats, oils, and sweets: use sparingly; and 7. Water. (c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed	A 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 093	Continued From page 24	A 093		

dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.
(d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months.
(e) Therapeutic diets shall be prepared and served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining or family style dining are not required to document what is eaten unless a health care provider ' s order indicates that such monitoring is necessary. However, the food items which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility.
2. The facility shall document a resident ' s refusal to comply with a therapeutic diet and notification to the resident ' s health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 093	Continued From page 25	A 093		

resident ' s responsible party refusing the diet is acceptable documentation of a resident ' s preferences. In such instances daily documentation is not necessary.
(f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of _ the time between meals.
(g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand.
(h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 093	Continued From page 26	A 093		

This Statute or Rule is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to comply with dietary standards. Specifically, 1). Failure to ensure foods were stored at safe temperatures which has the potential to affect all five current residents of the facility; and 2). Failure to ensure the weekly menus were dated, as required.

The findings include:

During the review of the facility's kitchen food service operations conducted , the following concerns were noted:

1. At 10:30 AM the surveyor observed the lunch entree, lasagna, was baking in the oven. At 11:30 AM, the oven was observed to be turned off and mostly cooled off, the lasagna was still in the oven. This was brought to the facility manager's attention, she acknowledged food should not be left in the turned-off oven and should have been refrigerated after cooking, or prepared closer to the resident's lunch time. She instructed a staff member to heat the lasagna to a proper temperature before serving it.

2. Four weeks of menu cycles were observed posted on the refrigerator in the kitchen. None of them were dated with the current week or any other date. In an interview conducted at 11:32 AM, the manager stated they just re-use the menus and do not date each week's menu with the current week.

Class III

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 125	Continued From page 27	A 125		
A 125 SS=D	58A-5.021(6) FAC Fiscal - Surety Bonds	A 125		

(6) SURETY BONDS. Pursuant to the requirements of Section 429.27(2), F.S.:
(a) A facility whose owner, administrator, or staff, or representative thereof, serves as the representative payee or attorney-in-fact for facility residents, must maintain a surety bond, a copy of which shall be filed with the agency. For corporations which own more than one facility in the state, one surety bond may be purchased to cover the needs of all residents served by the corporation.
1. If serving as representative payee:
a. The minimum bond proceeds must equal twice the average monthly aggregate income or personal funds due to residents, or expendable for their account which are held by the facility; or
b. For residents who receive , the minimum bond proceeds shall equal twice the supplemental security income or social security income plus the payments including the personal needs allowance.
2. If holding a power of attorney:
a. The minimum bond proceeds shall equal twice the average monthly income of the resident, plus the value of any resident property under the control of the attorney in fact; or
b. For residents who receive , the minimum bond proceeds shall equal twice the supplemental security income or social security income and the payments including the personal allowance, plus the value of any resident property held at the facility.
(b) Upon the annual issuance of a new bond or continuation bond the facility shall file a copy of the bond with the AHCA central office.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 125	Continued From page 28	A 125		

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to provide documentation of a surety bond, obtained to protect the financial interests for 1 out of 5 sampled residents (Resident #4) for whom the facility was the representative payee.

The findings include:

During an investigation, conducted [redacted] at 9:40 AM, the facility's administrator was asked and confirmed the facility was named as representative payee for Resident #4 related to his monthly social security payments.

At that time, he stated they did not have a surety bond and was not sure what a surety bond was for.

Class III

A 152 SS=D	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other	A 152	

(3) OTHER REQUIREMENTS.
(a) All facilities must:
1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and
2. Must be maintained free of hazards; and
3. Must ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order.
(b) Pursuant to Section 429.27, F.S., residents shall be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident [redacted] sleeping area must have at least the following furnishings:
1. A clean, comfortable bed with a mattress no

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 29	A 152		

less than 36 inches wide and 72 inches long, with the top surface of the mattress a comfortable height to ensure easy access by the resident;
2. A closet or wardrobe space for hanging clothes;
3. A dresser, chest or other furniture designed for storage of personal effects;
4. A table, bedside lamp or floor lamp, and waste basket; and
5. A comfortable chair, if requested.
(c) The facility must maintain master or duplicate keys to resident to be used in the event of an emergency.
(d) Residents who use portable bedside commodes must be provided with privacy during use.
(e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility shall be free of tears, stains and not be

This Statute or Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to maintain a living environment in clean and good working order, as required.

The findings include:

During a tour of the facility conducted beginning at 9:55 AM with the facility's manager present, the following concerns were noted:

1. In the next to resident #5's , the toilet paper holder was loosely attached to the wall with clear plastic tape. A coat hanger

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965505	A. BUILDING _____ B. WING _____	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 30	A 152		

was utilized as a substitute toilet paper holder and was hanging from the hand rail located next to the toilet.

2. In the [illegible] next to the pantry, the paint was chipping off shower tiles and was unsightly, there was no shower head, the tile located on the shower "step" near the toilet was deteriorated and unsightly, the finish on the toilet seat was partially worn off, and there was no toilet paper holder.

3. In the walk-in hallway closet used by multiple residents, the overhead fluorescent light was in disrepair and did not turn on.

4. In the [illegible] by residents #1 and #2, a strong [illegible] odor was noted when you entered the [illegible] continued into the [illegible] attached to this [illegible]. The door to the [illegible] [illegible] missing. In the [illegible], the toilet seat was laying on the floor next to the toilet, the toilet handle was [illegible], and water was "running" in the toilet. In an interview conducted on [illegible] at 10:07 AM, resident #2 stated both residents use this [illegible].

5. In the main resident [illegible] next to the living [illegible], the toilet paper holder and only towel holder in the [illegible] broken and the shower rod was rusty.

These concerns were discussed with and acknowledged by the facility manager who was present during the observations.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Sun Coast Residential Care
813 SW 9th Street
Hallandale Beach, FL 33009

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2012 by a representative from this office.

Attached is the provider's copy of the State (3020) 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. Staff from this office will conduct a review after , **2012** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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,

for Arlene Mayo-Davis
Field Office Manager

AMD/ls
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924