STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965505	**03/04/2019**
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 #2018014289, was conducted on . . . . . at Sun Coast Residential Care, License #9856. The facility had deficiencies identified at the time of the visit.

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

Based on record review and interview, it was determined that the facility failed to ensure all residents admitted to the facility were evaluated and assessed at least 60 days prior to admission or 30 days after admission, for 1 out of 2 sampled resident records reviewed (Resident #2).

The findings included:

Review of the file for Resident #2 revealed that the resident was admitted to the facility on . There was no contract or Resident Health Assessment (AHCA form 1823) observed in the file. Resident #2 was never assessed prior to admission to determine if the facility could met the residents needs or to know if he was a prior elopement risk before coming into the facility.

During an interview with the Administrator on . . . . . at 10:20 AM, it was stated that Resident #2 walked out the facility recently and went up the street; when the staff realized he was missing, I jumped into my truck and went to look for him. He was found in the front of the local corner store. After that, I put a lock on the gate. It was further stated that Resident #2 was missing less than an hour and that he usually goes outside to clean up the leaves.

During an interview with the Administrator on at 4:00 PM the findings were discussed and acknowledged, no further information was provided for review.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review, and interview, the facility failed to ensure that all residents had a Resident Health Assessment (AHCA form 1823) completed and ensured that all residents met the criteria for continued residency, for 1 of 3 sampled residents (Resident #1).

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The findings included:

During an interview with the Administrator on at 10:22 AM it was stated that Resident #1 has fits ( ) when he came out of rehab and that when he came to the facility he was on medications and was not but not very active. When Resident #1 started getting better he kept saying he wanted to go home. At the time, the Fire Protection , stated that we can't put a lock on the gate. The first time Resident #1 got away he went down the , he knocked on somebody's door, they called the police, and the police took him to the local Hospital and they released him here the same day. After that, we put a beam on the gate and then a week or so after he jumped over the fence and that's what we assumed because the gate was still locked. Resident #1 went to the same place again and they brought him here again than the Confidential State Agency got involved. I told them that we don't have the things to keep him here and they couldn't find another place for him until weeks later. He was getting stronger here but we couldn't keep him here.

Review of the file for Resident #1 admitted on revealed the Resident Health Assessment (AHCA form 1823) dated for revealed that the resident has a medical history and diagnosis of and a or behavioral status of forgetfulness. The resident was not documented as an elopement risk.

During an additional interview with the Administrator at 4:00 PM on , it was discussed that Resident #1 was admitted into the facility after each elopement without being re-assessed for continued residency after the resident had a significant change of being an elopement risk after having eloped prior. The Administrator was aware that the staff could not provide the care and services needed of providing the appropriate supervision needed to prevent the resident from eloping making the resident inappropriate at the facility. he findings were acknowledged by the administrator, no further information was provided for further review.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review and interview the facility failed to provide care and services appropriate to meet the needs of the residents (including supervision). As evidenced by failure to provide

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adequate supervision to prevent elopement(s), for 3 of 4 sampled residents (Resident #1, Resident #2 and Resident #5).

The findings included:

A) During an interview at 10:20 AM on with the Administrator, it was stated that the only elopement the facility has had recently was about a month or two ago. Resident #5 got out of the gate and started knocking on the lady's door next door, and she called the police because the lady didn't know that he belonged here. It was further stated that the staff found him before the police came and that it happened when Resident #5 first got here.
Review of the file for Resident #5 (admitted to the facility on) revealed a Resident Health Assessment (AHCA form 1823) from the previous facility the resident resided at dated for . Review of the 1823 form revealed that Resident #5 was never re-assessed upon admission to the facility and is not documented as an elopement risk at the facility the resident came from. Additional review of the 1823 form revealed that Resident #5 has a and behavioral status of alert and forgetful. There is no documentation of the form that the resident , has , or any form of . The resident requires assistance with all Activities of Daily Living (ADL's) except transferring in which the resident requires supervision and that the resident is independent with eating and ambulation. He requires daily oversight of wellbeing, whereabouts, and reminders for important tasks.

During an interview with the Administrator at 10:37 AM on it was stated that when the residents were eloping the staff were in the staff room. It was stated that when there is down time at the facility, that's where the staff will go and sit for a few minutes. It was stated that for each resident we had elope there was nothing on the 1823 forms or from the facility's they came from indicating that they were an elopement risk. There is no way for us to know here that they are a risk until it happens.

During an interview with Resident #5 at 12:12 PM on , it was stated that I don't remember ever leaving the facility and not coming out and that sometimes I go walking by myself when I feel like it. When asked do you know the area? It was stated "I don't remember." Interview with the resident revealed that the resident is only alert to person and not alert and oriented to place and time.

Upon request to review the facility's policy and procedures for elopements on at 2:33 PM from the Administrator, it was stated that the policy and procedures for elopements is in the residents contracts. Review of a blank contract revealed that residents are to inform staff upon leaving the facility, and sign in and out in a log provided to them. It was further stated, that "the residents family/legal representative has discussed and understands this facility's elopement, , and missing resident

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policy and understands that Sun Coast Residential Inc. cannot be responsible for the resident's health, safety, or welfare when they are away from the facility." Upon request to review the facility's elopement, , and missing resident policy the Administrator stated that he is unable to find them. It was acknowledged by the Administrator during this time, that in the event of an elopement the facility does not have a policy and procedure that could be found to assist the staff in the steps implemented to locate the missing resident. The findings were further discussed and acknowledged. No additional information was provided for review.

B) During an interview with the Administrator on at 10:22 AM, it was stated that Resident #1 had fits ( ) when he came out of rehab and that when he came to the facility, he was on medications and was not but not very active. When Resident #1 started getting better he kept saying he wanted to go home. At the time, the Fire Protection , stated that we can't put a lock on the gate. The first time Resident #1 got away he went down the , he knocked on somebody's door, they called the police, and the police took him to the local Hospital and they released him here the same day. After that, we put a beam on the gate and then a week or so after he jumped over the fence and that's what we assumed because the gate was still locked. Resident #1 went to the same place again and they brought him here again than the Confidential State Agency got involved. I told them that we don't have the things to keep him here and they couldn't find another place for him until weeks later. He was getting stronger here but we couldn't keep him here.

Review of Resident #1 admitted on revealed the Resident Health Assessment (AHCA form 1823) dated for revealed that the resident has a medical history and diagnosis of and a or behavioral status of forgetfulness. The resident was not documented as an elopement risk.

Upon request to review the staffing schedule from the months of and of 2018 for the staff present during the time the incident occurred, no schedules requested was ever provided.

During an interview with the Administrator on at 12:19 PM, it was stated that he threw them all away after the Re-licensure Survey and that the staff working at the facility during that time no longer works here.
During an additional interview with the Administrator at 4:00 PM on , it was discussed that Resident #1 was admitted into the facility after each elopement without being reassessed for continued residency and that the facility was aware that the staff could not provide the care and services needed to prevent the resident from eloping. Upon returning to the facility, the staffing was never increased to provide adequate supervision needed to prevent Resident #1 from further eloping. The finding were acknowledged, no further information was provided for review.

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C) During an interview with the Administrator on at 10:20 AM, it was stated that Resident #2 walked out the facility and went up the street; when the staff realized he was missing, jumped into my truck and went to look for him. He was found in the front of the local corner store. After, that I put a lock on the gate. It was further stated that he was missing less than an hour and that usually he goes outside to clean up the leaves so when he was outside the staff thought that is what he was doing.

Review of the file for Resident #2 revealed that the resident was admitted to the facility on . There was no contract or Resident Health Assessment (AHCA form 1823) observed in the file. Resident #2 was never assessed prior to admission to determine if the facility could met the residents needs or to know if he was a prior elopement risk before coming to the facility.

During an interview with the Administrator on at 4:00 PM the findings were discussed and acknowledged, no further information was provided for review.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(l)

Based on record review and interview, the facility failed to conduct and document at least two elopement drills per year.

The findings included:

Upon request to review the documented elopement drills on revealed that the last drill was conducted in of 2016.

During an interview with the Administrator at on at 4:00 PM, it was discussed that drills should be conducted bi-annually based on regulatory requirements. The findings were further discussed and acknowledged, no further documentation was provided for review

Class