STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910672	12/02/2016
NAME OF PROVIDER OR SUPPLIER **PACIFICA SENIOR LIVING FOREST TRACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **5500 NW 69TH AVENUE LAUDERHILL, FL 33319**	

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

0000 - Initial Comments

An unannounced re-licensure survey was conducted on 12/1/2016 and 12/2/2016 at Pacifica Senior Living at Forest Trace (License#7448). The facility had a deficiency identified at the time of the visit.

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

Based on record review and interview, the assisted living facility failed to maintain documentation of a contract rate and a signed dated consent for unlicensed staff to assist with self-administration of medication, for 1 out of 2 sampled residents (Resident#17).

The findings include:

Record review of Resident#17's file, found an admission date of with a diagnosis of high , Gaston , generalized , and . Record review also found documentation of Resident#17's health care surrogate on file.

Review of Resident#17's signed resident contract revealed it lacked documentation of her contract rate. Further record review of Resident#17's record revealed no evidence of a signed and dated informed consent for unlicensed staff to assist with Resident#17's medications.

During an interview with the Director of Nursing (DON) and the Administrator at approximately 12:00PM, they acknowledged the findings and stated no further information was available for review.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Pacifica Senior Living Forest Trace
5500 Nw 69th Avenue
Lauderhill, FL 33319

Dear Administrator:

This letter reports the findings of a state licensure and bed increase survey that was conducted on 1-2, 2016 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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