STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964952	**07/20/2017**
NAME OF PROVIDER OR SUPPLIER **ARDEN COURTS MANORCARE HEALTH**	STREET ADDRESS, CITY, STATE, ZIP CODE **5509 SWIFT ROAD** **SARASOTA, FL 34231**	

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

0000 - Initial Comments

An unannounced relicensure survey was conducted through at Arden Court Manorcare Health, an assisted living facility (license #9414) in Sarasota, Florida.

The following is description of the deficiencies.

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

Based on observation, staff interview, and record review the facility failed to provide nutrition in a safe and sanitary manner for facility residents. The person in charge of providing meals failed to perform their duties in a safe and sanitary manner. Improper food handling could lead to contamination and spread of to residents.

The findings included:

1. During meal observation on at 12:01 p.m., Staff A, was serving meals on the CloverDale module. She was serving the plates bare handed, placing her thumb on the eating surface of the plates. After placing the plates on the table, the assistant was observed helping residents with positioning or seating and then return to serving meals without sanitizing her hands. Staff A was observed repositioning beans on a plate with her bare hands when picking up plates from the service counter. Immediately after touching the beans, Staff A scratched her nose then picked up the plates and delivered them to the resident's table without sanitizing her hands.

2. On at 12:05 p.m. Staff B, with gloved hands, was observed delivering plates to tables, assisting residents with napkins and positioning and then returning to the serving counter to pick up two more plates. Staff B, using her gloved hand, rearranged the squash on one of the plates then proceeded to deliver the plates to the resident's table. The aide did not remove her glove and sanitizer her hands before handling new plates of food.

During the meal observation on , Staff C, the aide serving the food, left the kitchen with hands gloved and went to a resident , knocked on the door and entered. The aide returned to the kitchen and then removed the gloves from her hands.

3. In an interview on at 12:40 p.m., the food service manager said all staff are trained that when preparing and serving food and wearing gloves, gloves must be removed and hands sanitized between tasks. He said touching and positioning residents when wearing gloves, gloves must be changed before going back to delivering plates. The food service manager said lack of hand washing or sanitizing is

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unacceptable and all staff have received training in safe food handling.

4. A review of the safe food handling in-service syllabus found the staff are trained in proper hand hygiene. A review of the employee records finds the staff attended the safe food handling in-services.

Class III

N278 - LNS - Records - 58A-5.031(3) FAC

Based on a review of 1 (Resident #12) of 3 residents of a total of 5 residents receiving limited nursing care, and interview with administrative staff, the facility failed to ensure the monthly nursing assessment evaluated care issues for resident #12 resulting in no assessment being performed for a resident with a significant weight change.

The findings included:

1. Resident #12 began limited nursing services for the application and removal of braces on . The first monthly assessment was done on . On this assessment, the resident's weight at 230 pounds with braces. On , monthly assessment the resident's weight was noted to be 190 pounds. There was no assessment for this significant change in weight for this resident. This change reflected a 17% weight loss.

On , the monthly assessment noted the resident's weight was 191 pounds. No weight was documented on the ,17 assessment. On , the resident's weight was 220 pounds. This was a change of 13.6% of a weight gain. In , the resident's weight was 224.8 pounds which was a change from to of 15%. There was no documentation on any on the monthly assessments about these weight changes. A review of the resident's individual services from to there was no evidence of any assessment about this resident's change in weights.

On at 4:10 p.m. The resident service director said she looked in all of the documentation, both the record and in the computer, and there was no assessment about the resident's weight change. She did say in there was repeated documentation by the staff noting the resident had no . At 4:33 p.m., the Administrator said this lack of detail was the reason she had changed the resident service director nurse. She further said, the limited nursing service nurse comes monthly but she was apparently not paying attention to the weights.

Class III