STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964870	**09/26/2017**
NAME OF PROVIDER OR SUPPLIER **PACIFICA SENIOR LIVING FORT MYERS**	STREET ADDRESS, CITY, STATE, ZIP CODE **9461 HEALTHPARK CIRCLE FORT MYERS, FL 33908**	

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

0000 - Initial Comments

An unannounced relicensure survey was conducted through at Pacifica Senior Living, an assisted living facility (license #9346) located in Fort Myers, Florida.

The following is description of the deficiencies.

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record reviewed and staff interview, the facility failed to assure that 2 (staff B and C) out of 4 staff records reviewed included evidence of 3 hours of in-service training in resident behavior and needs and providing assistance with the activities of daily living.

The findings included:

Record review for Staff B found she was hired as resident care aid (RCA) on . Staff C was hired as RCA on .

Record review for both staff B and C found no evidence of 3 hours of in-service training in resident behavior and needs and providing assistance with the activities of daily living.

During an interview on at 1:10 p.m., the business office manager acknowledged the lack of training.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record reviewed and staff interview, the facility failed to obtain at least one hour of training in the facility's policy and procedures regarding ( ) within 30 days after employment for 1 (Staff B) out of 4 staff records reviewed.

The findings included:

Record review found that Staff B was hired as a resident care aid on . Further review revealed that staff B lacked training.

During an interview on at 1:00 p.m., the business office manager acknowledged the lack of training.

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Class III

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

Based on observation and interview the facility failed to assure that food was delivered in a sanitary manner. Unsanitary food delivery has the potential of spread of food borne illness to residents receiving an oral diet.

The findings included:

During the course of an observation on at 12:30 p.m., Staff A was observed touching Resident #13's wheel chair, while pushing resident to the dining . Staff A then brought Resident #14 from her the dining area. Staff A was observed walking and holding hands with Resident #14. Resident #14 grabbed staff A's hand and gave her a kiss in her hand. Staff A smiled. Staff A assisted Resident #14 to sit in her chair. Staff A did not wash her hands before she start pouring milk to glasses. One of the glasses over flowed. She took a napkin and wiped the floor. Staff A threw the dirty napkin to garbage and touched the garbage container. Staff A did not wash her hands. She then proceeded serving the milk touching the upper part of the glass with her fingers.

Staff B observed throwing a napkin at the garbage on at 12:32 p.m. She touched the garbage cover with her gloves. Staff B did not change gloves. She continued plating food and served to residents. She was touching the rim of the plate while she was serving. On at 12:35 p.m., Staff B was observed continuing using the same gloves. She poured a glass of milk for a resident and placed her fingers at the upper part of the glass while she was serving the milk.

A second observation began at cottage #2 on at 7:23 a.m., Staff E was observed wearing gloves while she was preparing coffee for residents. Staff E was observed opening packs of sugar and pouring the sugar into residents cups. Staff E dropped the pack to garbage and touched the lid of the garbage with her gloves. She then proceeded to opening the drawer getting a spoon and stirred the coffee. Staff E then served the coffee without changing gloves. She repeated the process 3 times while she was wearing the same gloves. After Staff E served coffee she was observed cooking scrambled eggs. She did not change gloves in between. She proceeded to the table and touched a residents shoulder with her hands while she was serving another resident a cup of coffee. She was observed still wearing the same gloves while she was serving juice or coffee to all 11 residents. Staff E did not change her gloves during the course of the observation. Staff E was observed on at 7:59 a.m., still wearing the same gloves. She proceeded to open a pack of pre-cut sliced bread. She took the bread out of the pack and placed it in the toaster using the same pair of gloves. She was observed opening the drawer taking out a

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knife and cutting sausage into pieces with the same gloves on still. She proceed taking the toast from the toaster still wearing the same gloves. She then sliced the pieces of bread one by one and started buttering them still wearing the same gloves. She then proceeded placing the toast on residents plates. During the course of the observation Staff E was wearing the same gloves.

Staff D was observed coming to the dining area to assist with serving on at 8:08 a.m., Staff D was not observed washing hands before she started serving. She was observed on at 8:09 a.m., serving plates to residents. Her hands were touching the rim of the plate. She then proceeded taking dirty cups from the table, placing them on the counter, and taking two more plates of food and serving the residents. Staff D did not wash her hands.

During an interview with the facility's dietary manager on at 9:12 a.m., she acknowledged that staff did not follow sanitary procedure while they were preparing and serving the food. She said she will in-service them immediately.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, record review, and staff interview, the facility failed to obtain a current menu approved by a registered dietician. Furthermore, the facility failed to have a menu posted a week in advance. In addition, facility failed to assure that the registered dietician has a current license.

The findings included:

Observation during tour conducted on from 9:30 a.m., to 10 :30 a.m., found that the menu posted at all five cottages expired on , 2017. Further observation revealed that the menu was not dated a week in advance. Menu also stated "Summer 2015."

During an interview with facility's dietary manager on at 11:10 a.m., it was confirmed that indeed the menu expired on , 2017. Said she has been asking the corporate office for a new menu, but no one got back to her. She also acknowledged that registered dietician license expired , 2017. She also said the menu posted was not dated a week in advance.

Class III

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

Based on record review and staff interview, the facility failed to obtain written informed consent for

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unlicensed staff to assist with medications for 2 (Resident #10 and #12) of 2 resident records reviewed.

The findings included:

Resident #10's file revealed an admit date of . Resident #10's file contained no written informed consent for unlicensed staff to assist with medications nor was such consent included in the resident contract.

Resident #12's file revealed an admit date of . Resident #12's file contained no written informed consent for unlicensed staff to assist with medications nor was such consent included in the resident contract.

On at 9:20 a.m., the Business Office Manager said that per corporate prior to 2016 the contracts did not have this included.

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