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
	AL11964870	A. BUILDING: _____ B. WING _____	08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING FORT MYERS	9461 HEALTHPARK CIRCLE FORT MYERS, FL 33908

(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the ... are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic ... submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ... ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 3 (Staff A, D, and E) of 4 staff records reviewed, had the employment status updated within 10 days of hire on the facility roster. This has the potential for staff with disqualifying offenses to have access to	CZ814		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ814	Continued From page 1 . . . . . adults. The findings included: Record review for Resident Aide/Medication Technician Staff A found a hire date of . The facility roster review found Staff A was added to the facility roster on . Record review for Resident Aide Staff D found a hire date of . . . . . The facility roster review found Staff D was added to the facility roster on . . . . . Record review for Resident Aide Staff E found a hire date of . The facility roster review found Staff E was added to the facility roster on . On at 9:45 p.m., the administrator confirmed Staff A, D, and E were not added to the facility roster in a timely manner. On at 10:24 a.m., the human resources manager said she was hired . . . in . . . and is still in the process off auditing all records for accuracy and compliance. She confirmed all three staff were not added to the facility roster within 10 days. Unclassified.	CZ814		
A 000	Initial Comments An unannounced state relicensure and limited nursing services survey was conducted on through at Pacifica Senior Living Fort Myers, an assisted living facility in Fort Myers, Florida.	A 000		

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A 000	Continued From page 2 The following is a description of the deficiencies found at the time of the visit.	A 000		
A 009	58A-5.0181(3) FAC; 400.0078(2) Admissions - Admission Package (3) ADMISSION PACKAGE. (a) The facility must make available to potential residents a written statement(s) that includes the following information listed below. Providing a copy of the facility resident contract or facility brochure containing all the required information meets this requirement. 1. The facility's admission and continued residency criteria; 2. The daily, weekly or monthly charge to reside in the facility and the services, supplies, and accommodations provided by the facility for that rate; 3. Personal care services that the facility is prepared to provide to residents and additional costs to the resident, if any; 4. Nursing services that the facility is prepared to provide to residents and additional costs to the resident, if any; 5. Food service and the ability of the facility to accommodate special diets; 6. The availability of transportation and additional costs to the resident, if any; 7. Any other special services that are provided by the facility and additional cost if any; 8. Social and leisure activities generally offered by the facility; 9. Any services that the facility does not provide but will arrange for the resident and additional cost, if any; 10. The facility rules and regulations that residents must follow as described in rule	A 009		

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A 009	Continued From page 3 58A-5.0182, F.A.C.; 11. The facility policy concerning [redacted] pursuant to section 429.255, F.S., and rule 58A-5.0186, F.A.C., and Advance Directives pursuant to chapter 765, F.S.; 12. If the facility is licensed to provide extended congregate care, the facility's residency criteria for residents receiving extended congregate care services. The facility must also provide a description of the additional personal, supportive, and nursing services provided by the facility including additional costs and any limitations on where extended congregate care residents may reside based on the policies and procedures described in rule 58A-5.030, F.A.C.; 13. If the facility advertises that it provides special care for individuals with [redacted] 's [redacted] and related [redacted], a written description of those special services as required in section 429.177, F.S.; and, 14. The facility's resident elopement response policies and procedures. (b) Before or at the time of admission, the resident, or the resident's responsible party, guardian, or attorney-in-fact, if applicable, must be provided with the following: 1. A copy of the resident's contract that meets the requirements of rule 58A-5.025, F.A.C., 2. A copy of the facility statement described in paragraph (a) of this subsection, if one has not already been provided, 3. A copy of the resident's bill of rights as required by rule 58A-5.0182, F.A.C.; and, 4. A Long-Term Care Ombudsman Program brochure that includes the telephone number and address of the district office. (c) Documents required by this subsection must be in English. If the resident is not able to read, or does not understand English and translated	A 009		

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A 009	Continued From page 4 documents are not available, the facility must explain its policies to a family member or friend of the resident or another individual who can communicate the information to the resident. 400.0078 2) Upon admission to a long-term care facility, each resident or representative of a resident must receive information regarding: (a) The purpose of the State Long-Term Care Ombudsman Program. (b) The statewide toll-free telephone number and e-mail address for receiving complaints. (c) Information that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. (d) Other relevant information regarding how to contact representatives of the State Long-Term Care Ombudsman Program This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a complete admission packet was available for new admissions to the facility. Failure to provide a complete admission packet leads to a lack of necessary information and may lead to misunderstanding between the resident or their representative and the facility. The findings included: 1. Review of the daily, weekly, or monthly charge for limited nursing services (LNS) and a list of all services provided revealed that it was inconclusive since Appendix B indicated the facility charged an all-inclusive fee for all services including LNS. However, there was one more form titled Appendix B and it indicated an all-inclusive rate and underneath, a charge of	A 009		

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A 009	Continued From page 5 $500 a month for LNS. The administrator acknowledged on at 9:58 a.m., there was a discrepancy in the verbiage since it can be a non-inclusive contract and at the same time an additional charge. She also said they do not charge for LNS and indeed they have an all-inclusive contract. She did not understand why there was a $500.00 fee. On at 10:00 a.m., the administrator was asked if she notified residents that are currently receiving home health services they can get the same service from LNS with no additional charge. The administrator could not provide evidence she notified residents currently receiving services from home health they can obtain the same services for no additional cost since the facility had the appropriate license. The administrator said they had no LNS residents in the facility. On at 10:45 a.m., the administrator retracted her previous statement. The administrator said she has been working for the company for a about a year and a half and she did not know for sure if they charged a fee for LNS or not. She said she had to call the corporate office to find out. 2. Record review of the facility's admission packet revealed the following information was not included: a. Personal care services the facility is prepared to provide to residents and additional costs to the resident, if any. b. Nursing services that the facility is prepared to provide to residents and additional costs to the resident, if any. c. The facility's resident elopement response policies and procedures. d. policy; e. Medication storage policy; f. Elopement policy;	A 009		

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A 009	Continued From page 6 g. Reporting . . . . . , neglect and , ... policy; h. Administration scheduled availability; i. control, sanitation, and universal precaution policy; j. Third party coordination policy (including coordination of communications). k. A Long-Term Care Ombudsman Program brochure that includes the telephone number and address of the district office. 3. The resident's handbook page #13 stated a reason for discharge is resident being: "bedridden as defined by state licensing regulations." On . . . . . at 10:02 a.m., when the administrator was asked how many days residents can be bedridden before they were given a discharge notice she replied, "14 days." Regulatory requirement for facility with a standard license or LNS license is 7 days not 14 days. Only facilities with extended congregate care services meet the criteria mentioned above. The facility does not hold an extended congregate care services (ECC) license. On at 10:03 a.m., the administrator confirmed the facility never had an ECC license. 4. Record review revealed the following information was excluded from facility's contract: a. A provision stating whether the facility is affiliated with any religious organization and if so, which organization and its relationship to the facility; b. A provision that residents must be assessed upon admission pursuant to subsection 58A-c.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule; c. The facility's policies and procedures for self-administration, assistance with self-	A 009		

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A 009	Continued From page 7 administration, and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule; and d. The agreement did not indicate the cost of moving and storage. Per regulatory requirements storage is not to exceed 20% of monthly fee. e. For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. 5. The administrator acknowledged on at at 1:00 p.m., the admission packet and contracts were incomplete. Class III	A 009		
A 054	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must 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 must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be	A 054		

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A 054	Continued From page 8 immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, 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 record review and staff interview, the facility failed to have medications in the facility in a timely manner for 3 (Resident #6, #11, and #12) of 3 records reviewed. The findings included: 1. Review of the medication observation record (MOR) for Resident #11 on [illegible] at 2:30 p.m., revealed medications were circled [illegible] through [illegible] as not being available. Resident #11 had not received [illegible] (used to treat [illegible] rhythm problems) 200 mg po daily, [illegible], ([illegible]) 7.5 mg 1 tab by [illegible] twice daily, [illegible], (debriding [illegible]) daily [illegible], to affected area, Voltaren ([illegible]) 1% apply [illegible], to affected area four times daily, [illegible] ([illegible]) [illegible], 250 mg one capsule by [illegible] twice daily, [illegible] ([illegible] softener) liquid 100 mg by [illegible] at bedtime, [illegible], (cognition-enhancing	A 054		

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A 054	Continued From page 9 medication) 10 mg by ... at bedtime, (cognition-enhancing medication) 5 mg by ... twice a day, ... 1 tab by ... daily, (, retention medication) 0.4 mg by ... at bedtime, ... (...) 2% apply , , daily, Triple ..., ..., three times a day. Medications of 2%, Triple ..., Voltaren and ..., did not say where to apply the . 2. Record review on at 9:00 a.m., of Resident #12's MOR dated ... through showed 30 mg tab by at bedtime scheduled for 8 p.m. Medication given once on . No other dates indicate medication as given. The MOR dated through showed ... 30 mg tab take one tab by ... at bedtime. MOR did not indicate medication was given. 3. Record review on ... at 10:00 a.m., for Resident #6 showed a medication observation record (MOR) dated ... through ... The medication , - , 25-100 take 1 tab by ... 4 x day was not given ..., ..., ... through , , Medication ... D3 2000 International Units by daily was not given through .... During an interview on ... at 10:20 a.m., the executive director said she had no explanation for this. Review of Medication policy, Med 09 - Medication Refills. Policy Date ..... 3. Medications are never allowed to run out unless directed to by the physician 5. When there is any	A 054		

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A 054	Continued From page 10 delay in the receipt of the medications that results in the unavailability of the medication to be given, the resident care director is notified. During an interview on ..... at 8:45 a.m., the executive director said she spoke with the wife of Resident #6 yesterday and she said she is filling them and delivering them from the pharmacy. The facility is still waiting on them to be delivered/filled. There is no backup pharmacy for medications that are not delivered timely. There was no documentation in Resident #6's chart the physician had been notified of the medications not being given. Class III	A 054		
A 056	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to	A 056		

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A 056	Continued From page 11 another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , . . . , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled	A 056		

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A 056	Continued From page 12	A 056		

or refilled in a timely manner.
(g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:
1. Practitioner's name,
2. Resident's name,
3. Date dispensed,
4. Name and strength of the drug,
5. Directions for use; and,
6. Expiration date.
(h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order.

This Statute or Rule is not met as evidenced by:
Based on record review and staff interview, the facility failed to have medications in the facility in a timely manner for 3 (Resident #6, #11, and #12) of 3 records reviewed.

The findings included:

1. Review of the medication observation record (MOR) for Resident #11 on at 2:30 p.m., showed many holes in the MOR. Medications had been circled through as not being available. Resident #11 has not received (used to treat rhythm

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A 056	Continued From page 13 problems) 200 mg po daily, . . . , . (. . . . . ,) 7.5 mg 1 tab by . . . twice daily, . . . , (debriding . . . . .) daily . . , . . to affected area, Voltaren (. . . . . ,) 1% apply . . , . . . , to affected area four times daily, . . , (. . . . .) . , . . . 250 mg one capsule by . . . twice daily, ... (. . . . softener) liquid 100 mg by . . . at bedtime, . . , . (cognition-enhancing medication) 10 mg by . . . at bedtime, (cognition-enhancing medication) 5 mg by . . . twice a day, ... 1 tab by . . . daily, ... (. . . . , retention medication) 0.4 mg by . . . at bedtime, ... (triple . . . . .) 2% apply . . , . . . , daily, triple . . . . . , . . . , three times a day. Medications of . . . . . 2%, (triple . . . . .), Voltaren and . . . did not say where to apply . . . . . . 2. Record review on . . . . . at 9:00 a.m., of Resident #12's MOR dated . . . through . . . . . showed . . . . . 30 mg tab by . . . at bedtime scheduled for 8 p.m. The medication was given once on . . . . . No other dates indicate medication as given. The MOR dated . . . . through . . . . . showed . . . . . 30 mg tab take one tab by . . . . at bedtime. The MOR does not indicate medication was given. 3. Record review on . . . . . at 10:00 a.m., for Resident #6 showed a medication observation record (MOR) dated . . . . through . . . . . The medication . . . . . , ... , ... 25-100 take 1 tab by . . . . 4 x day was not given through . . . . . Medication . . . . D3 2000 international units by . . . . daily was not given . . . . through	A 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964870	A. BUILDING: _____ B. WING _____	08/21/2019

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A 056	Continued From page 14 During an interview on . . . . at 10:20 a.m., the executive director said she had no explanation for this. Review of Medication Policy, Med 09 - Medication Refills. Policy Date ..... 3. Medications are never allowed to run out unless directed to by the physician. 5. When there is any delay in the receipt of the medications that results in the unavailability of the medication to be given, the resident care director is notified. During an interview on . . . . at 8:45 a.m., the executive director said she spoke with the wife of Resident #6 yesterday and she said she is filling them and delivering them from CVS. The facility is still waiting on them to be delivered/filled . . There is no backup pharmacy for medications that are not delivered timely. There was no documentation in Resident #6's chart the physician had been notified of the medications not being given. Class III	A 056		
A 081	58A-5.0191(.) FAC Training - Staff In-Service (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation	A 081		

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A 081	Continued From page 15	A 081		

which must be kept in the employee's personnel record.
(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:
1. Resident's rights; and,
2. The facility's license type and services offered by the facility.

(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:
(a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement.
(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:
1. Reporting adverse incidents.
2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.
(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the

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A 081	Continued From page 16 following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident . . . . . , neglect, and , . The facility must use its . . . . prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 2 (Staff D and E) out of 4 staff working in the facility completed the required training within 30 days of employment and participated in a 2 hour pre-service orientation prior to interacting with residents.	A 081		

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A 081	Continued From page 17 The findings included: 1. Record review for Resident Aide Staff D found she was hired on . . . . . . Staff D lacked the following trainings: 1 hour of in-service training in reporting major incidents and reporting adverse incidents and facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. There was no evidence on record that Staff D was provided with a copy of the facility's resident elopement response policies and procedure nor proof of and competency in the implementation of the elopement response policies. In addition, Staff D lacked training in resident rights in an assisted living facility and recognizing and reporting resident , neglect, and , ... Staff D also lacked a 2 hour pre-service orientation. 2. Record review for Resident Aide Staff E found she was hired on . . . . . . Record review for Staff E found she lacked the following trainings: 1 hour of in-service training in reporting major incidents and reporting adverse incidents, and facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation, 1 hour in-service training within 30 days of employment in safe food handling practices and in-service training regarding the facility's resident elopement response policies and procedures. There was no evidence on record that Staff E was provided with a copy of the facility's resident elopement response policies and procedure nor proof of and competency in the implementation of the elopement response policies.	A 081		

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING FORT MYERS	9461 HEALTHPARK CIRCLE FORT MYERS, FL 33908

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A 081	Continued From page 18 Staff E lacked 1 hour in-service training that covered the following subjects: a. Resident rights in an assisted living facility. b. Recognizing and reporting resident , neglect, and , Staff E also lacked a 2 hour pre-service orientation. 3. On at 1:00 p.m., the administrator acknowledged the lack of training. Class III	A 081		
A 082	58A-5.0191(4) FAC Training - / (4) / (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure completion of , / , , (/) training for 2 (Staff D and E) out of 4 staff record reviewed. The findings included:	A 082		

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A 082	Continued From page 19 Resident Aide Staff D was hired on . Caregiver and Medication Technician Staff E was hired on . . Staff D and E record review found no documentation of completion of / training. On at 1:00 p.m., the administrator acknowledged the lack of training. Class III	A 082		
A 086	58A-5.0191(10) FAC Training - ADRD (10) AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 64.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , , and , , shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " and Related Level I Training,"	A 086		

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A 086	Continued From page 20 must address the following subject areas: 1. Understanding 's and related ; 2. Characteristics of ; 3. Communicating with residents with 's ; 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with 's and Related ," dated , incorporated by	A 086		

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A 086	Continued From page 21 reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with . . . . . or related . . . . . , or 2. Three years of practical experience in a program providing care to persons with . . . . . or related . . . . . , or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with . . . . . or related . . . . . . (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college	A 086		

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A 086	Continued From page 22 or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain the Level I, 4 hour and related training for 1 (Staff D) out of 4 staff records reviewed. The findings included: The facility has a memory unit and advertised it provides services for residents with and memory related . . . . . . Record review for Staff D found she was hired as a resident aid on . Further review found no documentation of the Level I, 4 hour and related training for Staff D. On at 1:00 p.m., the administrator acknowledged Staff D lacked the required training. Class III	A 086		
A 090	58A-5.0191(11) FAC Training - . . . . . . (11) . . . . . TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in	A 090		

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A 090	Continued From page 23 resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . . . . . . (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 staff interview, the facility failed to obtain at least one hour of training in the facility policy and procedures regarding . . . . ( ) within 30 days after employment for two (Staff D and E) out of four staff records reviewed. The findings included: Record review found that Staff D was hired as a resident care aide on . . . . . Further review revealed that Staff D lacked training. Record review found that Staff E was hired as a resident care aide on . . . . . Further review revealed that Staff E lacked training. During an interview on at 1:00 p.m., the business office manager acknowledged the lack of training. Class III	A 090		

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A 093	Continued From page 24	A 093		
A 093	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through 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 facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the	A 093		

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A 093	Continued From page 25 facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. 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 must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must 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 that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein	A 093		

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A 093	Continued From page 26 food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of . . . . . the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must 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, must be on . . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on . . at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority This Statute or Rule is not met as evidenced by: Based on record review and staff and resident interview, the facility failed to ensure the menu was posted and was visible and accessible to all residents. The facility also failed to encourage residents to participate in menu planning. The findings included: 1. Observation on . . . . . at 7:30 a.m., at cottage #2, the menu was posted on the wall in the main	A 093		

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	AL11964870	A. BUILDING: _____ B. WING _____	08/21/2019

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A 093	Continued From page 27 living room. The menu was high on the wall about 6 from the floor. The print used was very small. During the course of the observation Resident #1, #2, #3, and #4 were all present sitting at the main living room. All 4 residents complained the menu was up high on the wall and they could not read it. They also said no other menu was made available to them. Telephone interview with the Long Term Care Ombudsman on at 8:21 a.m., revealed an ombudsman was in the facility on and the menu was posted up high on the wall in an area where residents could not see it. The ombudsman said the print was too small and the residents could not read the menu. The ombudsman said several residents complained they could not see the menu. Observation on from 8:30 a.m. to 10:00 a.m., found the menu posted at cottage #1, #3, #4, and #5 was posted on the wall in the main living room. The menu was about 6 from the floor. On at 11:19 a.m., the administrator acknowledged the menu posted at all 5 cottages was too high up on the wall and in very small print. The administrator said they will be transitioning to have the menu on a TV screen all day. On at 7:15 a.m., a second observation found the menu at cottage #2 was still up high on the wall and in small print. On at 8:00 a.m., the certified dietary manager confirmed the menu was posted up too high and the residents could not see it. The certified dietary manager said she was aware of	A 093		

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A 093	Continued From page 28 the issue for some time now and had brought it to the administrator's attention. 2. On at 7:50 a.m., Resident #1 said, "the food is good, but to be honest with you they can do better. I asked them for corn beef for breakfast. I got it only once. They could provide more variety. There are no food meetings. I have been here long time. We met only maybe once or twice for the whole time I've been here. Look, I was in the restaurant business all my life, I know the drill. They should get together with us and talk to us about food. Its simple. The kitchen lady came and had a meeting with us weeks ago. It was the first time. There is no involvement on our end. A person in California reviews the menus for people who live in Florida. That does not make any sense. How can a someone in California know what we like in Florida. That is ridiculous. I am a meat and potato guy that is what I ate all my life. Not that much of that here." On at 8:45 a.m., Resident #3 said, "No, we never meet and discuss about food. Only one time they came and talked to us 2 weeks ago or so. Never before. No, they don't ask us what we like. I personally like a Philly sandwich being from Pennsylvania and all. No, they never offer that kind of thing. I know the person that does the menu is on the other side of the country. To be honest with you I was surprised when they put the meeting together. Said she will try. Will see. Don't believe anything will change." On at 8:20 a.m., Resident #4 said, "Food its ok. Nothing to write home about. We never meet. No that never happened. I have no idea what is on the menu. Can't even see it, it's up on the wall. No I can't read that menu. They know.	A 093		

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A 093	Continued From page 29 Its been like that for a very long time." On . . . . . at 9:15 a.m., Resident #5 said, "Food its ok. No, we never meet. No, we don't have a say about the menu. Look, the menu is up there on the wall. How tall do they think we are? No, I can't read that menu. I don't even know what is on the menu until I sit at the table." During an interview on at 1:00 p.m., the administrator confirmed the residents have no input on the menu. The administrator said she used to put meetings together when she started with the company a year and a half ago. She said she stopped the meetings due to the fact that they did not have residents that were able to participate due to functional decline. She said they just resumed the meetings a couple of weeks ago since they started getting a lot of food complains. She said she was not aware that residents could have input on menu. She said the facility corporate office was in California, their corporate dietician was in Chicago and was responsible for all menus for all communities. The administrator said she never sends any residents' suggestions to the dietician in order to modify the menu. On . . . . . at 7:30 a.m., the kitchen manager confirmed they had the first meeting two weeks ago. The kitchen manager said the facility's population has changed and cottage #1 and #2 have more alert residents. The kitchen manager said she was aware of residents' food complains. She said it is a work in progress and she tried her best to meet their needs. Class III	A 093		

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A 181	Continued From page 30	A 181		
A 181	58A-5.026(2) FAC Emergency Plan Approval (2) EMERGENCY PLAN APPROVAL. The plan must be submitted for review and approval to the local emergency management agency. (a) If the local emergency management agency requires revisions to the emergency management plan, such revisions must be made and the plan resubmitted to the local office within 30 days of receiving notification that the plan must be revised. (b) A new facility as described in Rule 58A-5.023, F.A.C., and facilities whose ownership has been transferred, must submit an emergency management plan within 30 days after obtaining a license. (c) The facility must review its emergency management plan on an annual basis. Any substantive changes must be submitted to the local emergency agency for review and approval. 1. Changes in the name, address, telephone number, or position of staff listed in the plan are not considered substantive revisions for the purposes of this rule. 2. Changes in the identification of specific staff must be submitted to the local emergency management agency annually as a signed and dated addendum that is not subject to review and approval. (d) The local emergency management agency is the final administrative authority for emergency management plans prepared by assisted living facilities. (e) Any plan approved by the local emergency management agency is considered to have met all the criteria and conditions established in this rule. This Statute or Rule is not met as evidenced by:	A 181		

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A 181	Continued From page 31 Based on record review and staff interview, the facility failed to obtained an approved comprehensive emergency management plan (CEMP). The findings included: Record review found the facility submitted their CEMP to the local county emergency management agency on . The facility's plan was rejected on . The CEMP was resubmitted on . The facility administrator followed up with an email to the local emergency office on . The staff from the local county emergency management agency replied the same date saying the plan is still under review. On at 11:14 a.m., the administrator confirmed that plan was not yet approved by the local county office. Class III	A 181		