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
	AL11964922	A. BUILDING: _____ B. WING _____	11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING OF PALM BEACH	4760 JOG ROAD GREENACRES, FL 33467

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A 000	Initial Comments An unannounced licensure complaint survey, #2019017380, was conducted on , , and , at Pacifica Senior Living of the Palm Beach. There was a deficiency at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to provide supervision appropriate to the safety and needs of the residents residing in the facility, for 4 of 5 sampled Residents (Resident#1, Resident#3, Resident#4 and Resident#5). As evidence of the facility failure to provide appropriate supervision in each of the 7 cottages (Cottage #1-#7) resulting in aggressive behavior and fights by residents that suffer from [redacted]. It was also noted the facility failed to immediately intervene and implement a system to prevent the reoccurrence of aggressive behaviors by the residents. The Findings Included: On [redacted] at 3:53 PM, an interview with Resident#1's Case Manager revealed, Resident#1 moved into the facility on [redacted] and had resided at the facility for 3 weeks ([redacted]) when he was [redacted] the first time. She stated she received a call on [redacted] at	A 025		

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A 025	Continued From page 2 approximately 10 AM / 11 AM and was informed that the resident had been transferred to the hospital. The Case Manager was told by the facility initially that Resident#1 and hit his . . . . When the Case Manager arrived at the Emergency Room and spoke to Resident#1; she was told by the resident, that a resident who he did not know, came into his private room, and . . . . . in his toilet and attempted to use his electric razor. When Resident#1 tried to stop him, the resident punched him in the . . . , knocking him to the ground where he hit his . Resident#1 stated he doesn't know who the resident was or where he lives. The case manager reported the information to the facility Director of Nursing (DON). The Case Manager was told an investigation was conducted, and the resident responsible for the was identified, (no name given), but she was told the resident responsible for the lives in the Cottage#4 and was in Cottage#6, to participate in activities. Further interview with Resident #1's Case Manager revealed on , she received a call at approximately 1:30 AM from the facility Certified Nursing Assistant (CNA) and was told the resident had been taken to a local hospital. She asked to speak to someone in charge. The DON called her and stated the resident had soiled himself and had stepped into the hallway to ask for assistance, and one of the residents him in the hallway. The second incident was witnessed by staff. Law Enforcement (LE) was called and the resident responsible for the . . . . (Resident#3) was . . . . . for battery. After the second , the Case Manager insisted the facility pay for 24 hour one- on- one assistance to protect the resident until he could be moved to another facility. The facility reluctantly did so. Resident#1 has a history of	A 025		

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A 025	Continued From page 3 . . . . . , limited mobility, and difficulty verbalizing. She felt the facility was not proactive when it came to protecting the resident. When they visit the facility there is always two staff persons on duty for an average of 14 residents. There have been no safety measures put in place to protect residents who are potentially exposed to Resident#3. On during a confidential staff interview, it was revealed that there had been an altercation between two residents in Cottage#6 (Resident#4 and Resident#5), LE was called and no one was or . The confidential staff further stated , Cottage#6 is populated with residents who have behavioral issues. Review of the incident report involving Resident#4 and Resident#5 revealed the following. On . . . . . at 6:45 AM, Resident#4 hit Resident#5 on the with a book. Resident#5 received a . . . . on . . . . and visible scratches on her right arm. Several incidents were documented on . . . . . Resident#4 and Resident#5 had a yelling incident where Resident#5 reported she was scratched by Resident#4, on Resident#5 was yelling in the bathroom at Resident#4, and on , Resident#4 and Resident#5 were arguing and Resident#4 struck and kicked staff member. Record review revealed the facility had implemented no intervention to separate Resident#4 and Resident#5 prior to surveyor intervention on . . . . . On . . . . . at 10:41 AM, during an interview with Resident #5's representative , it was revealed the resident has lived at the facility since . She has some and can be	A 025		

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A 025	Continued From page 4	A 025		

possessive with her items. She is very friendly and is usually not aggressive toward others. He is aware that she was recently moved to another cottage as she was not getting along with her previous roommate. He believes there can be more staffing, there has been times when he visits there is only one staff member in Cottage#6.

On , a review of the facility incident reports dated at 10:30 AM, documented Resident#1 in his room and has injury to the of and his right . The resident was alert and responsive, the was stopped, and there was no witness of the . The resident was sent to local hospital for treatment. Further review revealed an incident report dated 8:40 PM and documented Resident#1 was involved in a witnessed altercation with Resident#3, which resulted in the resident being sent to the hospital with a , and Resident#3 being for battery by the local police.

A review of Resident#1's Health Assessment (AHCA Form 1823) dated documented Resident#1 medical history as , and History of ( ). or sensory limitations: Quick temper when someone enters his room and will strike out. Review of Resident#3's AHCA Form 1823 dated , documented Resident#3 medical history as , , and . Further review revealed behavioral status as due to other medical condition. Special Precautions noted as monitor for safety.

On , the Administrator provided the surveyor written staff statements regarding the

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A 025	Continued From page 5 incident(s) of Resident #1 and #3. A review of staff (present during the altercations) written statements were reviewed and revealed the following. The DON documented Resident#1 returned from the hospital, he gave a statement to the DON that when he went into his room this morning and found someone using his toilet. Resident#1 stated the man tried to use his razor. When he told the man no, the man hit him and pushed him over. Resident#1 stated he had never seen the man before. The DON stated Resident#1 was shown the male roommates in Cottage#4 and responded no, that neither house mate was the man who pushed him. On . . . . . , the DON documented, after reviewing statements from staff, the DON approached Resident#1 to identify Resident#3 who was seen in the area at the time of the incident. Resident#1 responded , "yes, that looks like it's him". Staff B's statement dated . . . . . , revealed Resident#1 came to her in the kitchen area with on his . He said a man came in his room to take his razor and when he told him no , then the person pushed him over. Staff B documented Resident#3 was observed walking down the hall. During an interview with Staff B on . . . . . , her verbal statement was not consistent with her initial written statement, as she stated Resident#1 did not tell her what happened. A written statement was reviewed from Staff D dated . . . . . , who documented she received a call from caretaker in Cottage#4 (no name given), that Resident#1 was being by another resident. On approach, Staff D observed Resident#3 with 2 . . . . around Resident#1's shaking him violently. As she got closer, she observed . . . . on Resident#1 . . . and Resident#3 kept hitting Resident#1. Staff D called 911 for assistance. A written statement was reviewed from Staff E dated	A 025		

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A 025	Continued From page 6 . . . . . , who documented Resident#1 was coming from the hallway to ask for help with his pants and Resident#3 who was in the hallway at the time. Resident#3 began to hit Resident#1 on his . . . and choke him. During an interview with Resident #3's wife on . . at 1:05 PM, the following was revealed. She stated she was very disappointed and upset about the services and supervision received at the facility. She also expressed concern regarding the fact that her husband who has . . . . . , was . . . . . as a result of the incident. She stated Resident#2 moved into the facility . . . . . (17 days prior to the incident). She stated she spoke in length with the Administrator regarding Resident#3's history to include frequent and admissions to Behavioral Units, as he was coming to the facility from a behavioral unit after a two week . She stated she informed the Administrator of her husband's severe , Mental Health, severe sundowners, and the constant need for supervision. She informed the Administrator her husband, can be very combative and gets very which result in him having mental episodes. The facility also called and the previous facilities and the behavioral unit to obtain behavioral history prior to accepting the resident. She was ensured by the Administrator that the facility would be able to accommodate the residents supervision and care needs. She stated prior to the incident she was not aware of any prior issues with behavior. She stated the facility requested that she not visit for 2 weeks to give the resident a chance to get acquainted with the facility, staff, and residents. She was requested to come to the facility prior to the 2 week period as the resident was having an assessment done by the facility nurse. During this visit there was no	A 025		

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A 025	Continued From page 7 agitation observed. She stated her husband was there for a total of 17 days prior to the incident. She stated the facility did not provided the supervision they promised, which resulted in her husband being . . . . . for battery. Interview with staff members revealed, Staff C on at 12:53 PM, stated on the night of the incident . . . . . , she was working in Cottage#4, she and another staff member (who no longer works for the facility) was assisting a new resident to bed. She stated she heard Resident#1 say help me and she observed Resident#1 trying to come out of his room and Resident#3 was blocking him, did not see him hit the resident but saw Resident#3 with his around Resident#1 . . . . . Interview with Staff D at 6:19 PM, she stated she was the Float Med -Tech on the 3pm-11pm shift on , and she was in Cottage#1 and was called and informed that Resident#3 had . . . . . Resident#1. She stated Resident#3 can be aggressive with staff members and chase them. Staff D declined to discuss any information regarding staffing or lack of. She stated there is 2 direct care staff in each cottage. On , the facility staffing schedules for . . . . . and . . . . . were reviewed, there are 2 staff members scheduled on the 7 AM-3 PM and 3 PM-11 PM shift for each of the 7 cottages; with 1 float person and 1 Licensed Pratical Nurse (LPN) to cover 7 cottages on these shifts. On the 11 PM -7 AM shift there is one direct care staff person per cottage, and 1 float person for 7 cottages. On . . . . . day shift (7 AM-3PM) there were 2 direct care staff assigned (11 residents) to Cottage#4, 2 float med techs, and 1 LPN. On (3PM-11PM) shift there were 2 direct	A 025		

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A 025	Continued From page 8 care staff assigned to (12 residents) Cottage#4, 1 float Med tech and 1 LPN. On , 11 PM -7 AM shift there was 1 direct care staff person assigned to (14 residents) in Cottage#6. Further record review of the investigation into the incident that occurred with Resident#1 on revealed it was incomplete. There was conflicting statements from the DON and the Administrator, leaving the supervision issue unresolved, and no measures were put in place to ensure the safety of the other residents. Information received from the DON and the Administrator, resulted in an incomplete investigation. There were no documented safety measures put in place to ensure the safety of 11 residents (in Cottage#6 and Cottage#7), where Resident#3 has potential access. Further review revealed no specific care plan to include supervision, for Resident#3, #4 and #5 who were admitted with potential safety related behaviors, that would require specialized supervision. During an interview with the Administrator on at 2PM revealed, upon completion of their investigation, they were unable to positively determine / or verify Resident#1 was assaulted by Resident#3, or if he . There was no documentation of any safety measures or follow-up procedures that would prevent future incidents with other residents. During an interview with the Administrator on at approximately 2:00PM, she acknowledged the findings and provided no additional documentation for review. Class II	A 025		