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
	AL11965265	A. BUILDING: _____ B. WING _____	03/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING OF BELLEAIR	620 BELLEAIR ROAD CLEARWATER, FL 33756

(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
A 000	Initial Comments A complaint investigation (complaint number 2020002652) was conducted at Pacifica Senior Living of Belleair on . There were deficiencies at the time of the survey.	A 000		
A 025 SS=D	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 independently in the community.	A 025		

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A 025	Continued From page 1 (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 observation, record review and interview, the facility failed to provide care and services appropriate to meet the needs of residents that were admitted to the facility and at risk for . Additionally, the facility failed to contact residents' health care providers and responsible parties related to incidents and failed to follow their own policy and procedures for incident reports and care plans. The facility failed to update resident records regarding changes in condition for two Residents (#4 and #9) who were at risk for and injury from . Findings Included: During an observation in Cottage 7, conducted on at 10:00am, Staff B informed Staff A that she was going on break. There were no other staff scheduled in Cottage 7 during the survey. From 10:04am through 10:16am, Staff A was assisting Resident #9 with medications and the resident was sitting sideways in her wheelchair with her toward the edge of the chair's	A 025		

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A 025	Continued From page 2 seat. The wheelchair appeared to be an inappropriate size for the resident and Staff A did not assist the resident to a more upright position in the chair. At 10:40am, Resident #9 continued to be in her wheelchair sitting sideways with her toward the edge of the chair's seat. No staff attempted to assist the resident into a more upright position. A record review for Resident #9, conducted on , revealed that Resident #9 required assistance with all activities of daily living (ADLs) according to the health assessment dated and was at risk for . The only care plan in the resident's record was dated that stated that the resident required reminders for all ADLs. There were no interventions identified to meet the resident's needs for . Resident #9 incurred several and other incidents, which led to hospitalizations for and and from through . The incident reports reviewed were incomplete (Photographic Evidence Obtained) and inconsistent with the minimal documentation in the resident's record. There was no evidence that Resident #9's health care provider and Responsible Party were notified for each incident. There were no interventions for prevention implemented with each or incident occurrence. There were no Narrative Charting notations in the resident's record since and did not include the events surrounding the resident's most recent and . There was no evidence that the Facility provided close monitoring for Resident #9 as the required. A record review for Resident #4, conducted on , revealed that the resident was admitted to Hospice services on .	A 025		

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A 025	Continued From page 3 There was not documentation in the resident's record regarding the resident decline in condition that necessitated the resident's admission to Hospice services. There were no incident reports or Narrative Charting notations in the resident's record for the reason that the resident went to the Hospital on an unknown date and returned to the Facility under Hospice care on . There was no evidence found that Resident #4's health care Provider or Responsible Party were notified related to the need for Hospitalization. Resident #4 did not have a Mobility Evaluation or a Care Plan in the resident's record. A review of the Management Policy and Procedure (FMP&P), conducted on , revealed that the FMP&P stated that residents would be identified upon admission of their risk for and that "staff must be aware" of residents at risk. The FMP&P stated that upon admission that each resident would have an Ambulation and Mobility Evaluation and initial interventions would be implemented. The FMP&P stated that upon a the staff would "complete an Occurrence First Responder Worksheet and implement initial interventions as indicated on the document" and "staff will follow procedures and complete appropriate documents as outlined in the Unusual Occurrence Policy and Procedure". The FMP&P stated that "the RS Care Director will use the Post- Tracking & Intervention form to analyze each and implement new interventions" and "initiate the process upon the first and analyze each subsequent as directed on the form". All forms were to be stapled together and placed in the Management Binder. An attempt to review the Management Binder, conducted on , revealed that	A 025		

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A 025	Continued From page 4 there was no . Management Binder to review. During an interview with the Resident Care Director, conducted on at 03:07pm, the Resident Care Director stated that "I don't have a Management binder yet" and "I am in the process to put a . tracking system in place". The Resident Care Director stated that Care Plans "are supposed to be updated quarterly" and "I am working at getting everyone's Care Plan updated". Class III	A 025		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for	A 055		

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A 055	Continued From page 5 whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it	A 055		

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A 055	Continued From page 6 is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain centrally stored medications (meds) in a locked cabinet, cart, receptacle, or room at all times. Findings Included: During an observation of the med pass with Staff A for Residents #7, #8, #9, and #18, conducted on . Staff A left meds unlocked and unsecured many times during the med pass. At 10:04am, Staff A left the med room door wide open when the staff went to retrieve Resident #9 from the front porch. Staff A brought Resident #9	A 055		

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A 055	Continued From page 7 into the med room and left the resident in the med room when the staff went into the kitchen to wash her . At 10:15am, Staff A left the med room door wide open when she wheeled Resident #9 outside to the front porch and returned at 10:16am with Resident #8. Staff A had Resident #8 sit in a chair in the med room and left from the med room to go wash her in the kitchen. At 10:21am, Staff A left the med room door wide open when she escorted Resident #8 outside to the front porch and returned with Resident #7 at 10:22am. Staff A parked Resident #7's wheelchair with the resident in it in the med room and left from the med room to go wash her in the kitchen. At 10:40am, Staff A left the med room door wide open when she escorted Resident #7 outside to the front porch and returned with Resident #18 and had the resident sit in a chair in the med room while the staff went into the kitchen to wash her . There were meds in a cabinet that was unlocked throughout the med pass (See Photographic Evidence2). A review of the Med Storage Policy and Procedure, conducted on , the Med Storage Policy and Procedure stated that "all medications, including over the counter, are kept in locked storage at all times". During an interview with the Resident Care Director, conducted on , the Resident Care Director stated that "yes, meds are to be locked at all times. Class III	A 055		