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 _____	12/03/2020

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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CZ830 SS=C	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		

AHCA Form 3020-0001

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

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CZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) The agency may adopt rules relating to emergency management planning, communications, and operations. Licensees	CZ830		

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CZ830	Continued From page 2 providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to report its daily emergency status, planning or operations information through the Agency's Emergency Status System (ESS). The findings are: Review of the Agency reporting update dated on indicated that pursuant to the State of Florida Governor's Executive Order 20-51 and at the direction of State Surgeon General regarding the Coronavirus . . . . . (COVID-19), the Agency established the event "COVID-19 Monitoring" in the ESS to monitor health care facility census, inventory, needs, and other related facility information. Further review of this update indicated that each assisted living facility must report its current bed census, available beds and additional COVID-19 status daily by 10:00am. Review of the Agency reporting update dated on . . . . . indicated that each facility must meet ESS reporting requirements and it was imperative that facilities continue to report daily in the ESS to maintain up to date and accurate information. Review of this update indicated that the Agency was going to cite facilities for deficiencies relating to this daily 10:00am reporting deadline. Further review of this update indicated that the Agency made descriptions for facilities to report correctly available at http://ahca.myflorida.com/COVID-19_Facilities.shtml#facility.	CZ830		

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CZ830	Continued From page 3 Review of the facility's ESS data entries it indicated that the facility did not enter and update its daily ESS information from to In an interview with the administrator on at 2:05pm, she stated that she had access to the facility's ESS portal and she was responsible to update the facility's ESS information. She stated that she did not update the facility's ESS information from until present and she understood that the facility's ESS information must be updated daily on or by 10:00am. Unclassified	CZ830		

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A 000	Initial Comments An unannounced licensure Complaint survey (complaint numbers 2020001826, 202000988 1 and 2020018997), Focused Control and Generator Monitoring Survey was conducted at Pacifica Senior Living of Palm Beach from to . The facility had deficiencies at the time of the survey.	A 000		
A 030 SS=D	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The	A 030		

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A 030	Continued From page 1	A 030		

telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and universal precautions; and,
8. The requirements for coordinating the delivery of services to residents by third party providers.
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where

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A 030	Continued From page 2 residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical . . . . . by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue	A 030		

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A 030	Continued From page 3 the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , , the guardian shall be	A 030		

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A 030	Continued From page 4 given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local	A 030		

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A 030	Continued From page 5 long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and [illegible], Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated [illegible] or [illegible] under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to develop and implement [illegible] control guidelines as directed by the Centers for [illegible] Control and Prevention (CDC) to ensure the health, safety	A 030		

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A 030	Continued From page 6 and well-being of its residents and to prevent the transmission of the Coronavirus (COVID-19). The facility failed to ensure the administrative oversight to assess, implement, evaluate and monitor their preparedness for response to the COVID-19 pandemic. This was evidenced by the facility's failure to implement and establish adequate screening protocols to be followed by the staff and failure to ensure that COVID-19 positive and negative residents were properly within the facility to prevent continued spread of the . This directly affected all residents in the facility which resulted in 17 out of 64 residents to be confirmed with a COVID-19 diagnosis (residents #16, 18, 19, 20, 21, 22, 23, 25, 27, 28, 29, 30, 31, 32, 34, 36 and 37) and led to the hospitalization of 5 residents with COVID-19 symptoms (residents #19, 21, 22, 23 and 30). The findings are: On , , The Office of the Governor of Florida issued Executive Order Number 20-51 directing the Florida Department of Health to issue a Public Health Emergency. The Executive Order documented, "Coronavirus 2019 (COVID-19) is a severe acute , , illness that can spread among humans through , transmission and presents with symptoms similar to those of ." Section 2 directed the State Health Officer to take any action necessary to protect the public health. Section 3 directed the State Health Officer to follow the guidelines established by the CDC (Centers for Control and Prevention) in establishing protocols to control the spread of COVID-19. On , The Office of the Governor of	A 030		

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A 030	Continued From page 7 Florida issued Executive Order Number 20-52 declaring a state of emergency for the entire State of Florida as a result of COVID-19. The CDC documents individuals who are 65 years and older, those with underlying medical conditions, and those living in long-term care facilities are at high risk for developing serious complications from COVID-19 illness. Individuals who are could develop serious with difficulty breathing and might require intensive care for the treatment of multi-organ failure, , failure, and . COVID-19 is a new , caused by the new Coronavirus that has not previously been seen in humans. Currently, there is no and no approved treatment for COVID-19 , which is a highly transmissible . See generally, Publications of the Centers for Control. The CDC guidelines indicate that the COVID-19 is thought to spread mainly through close contact from person-to-person, and that the best way to prevent the illness is to avoid being exposed to the . Ways to slow the spread of the include maintaining good social distancing, hygiene, use of cloths, and routine cleaning and of frequently touched surfaces. Review of the CDC guidelines titled "considerations for Preventing Spread of COVID-19 in Assisted Living Facilities" dated on included the following: - If COVID-19 is identified or suspected in a resident, the facility must this resident in their room and notify the health department.	A 030		

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A 030	Continued From page 8 - Maintain social distancing of at least 6 . . . between all residents while providing all necessary services. - If a COVID-19 resident required more assistance that can be safely provided or could not be . . . . . in their room, the facility should consider transferring this resident to a facility that is equipped to adhere to recommended . . . . prevention and control practices. Review of the facility's control policies and procedures (ICPP) provided by the Administrator for review on , indicated that these were updated on . . . . . In an interview with the administrator on at 2:00pm, she stated that the facility used a similar version of these ICPP since , of 2020 with no significant changes in procedures for the control and prevention of COVID-19. Review of the facility's ICPP indicated that COVID-19 is a . . , . . . , illness which may be spread from person to person by close physical contact, through . . , . . . , droplets when coughing or sneezing and by touching surfaces or objects before touching one's . . . , or , . . Review of these ICPP indicated that to prevent the introduction of COVID-19, the facility must follow CDC and Department of Health (DOH) recommendation regarding the proper screening of staff and residents and cohorting of residents. Review of the facility's ICPP titled "screening of staff, residents and visitors" indicated that all persons entering the facility must be screened for COVID-19 exposure, signs and symptoms. Review of this ICPP indicated that every staff member must be screened before each work shift	A 030		

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A 030	Continued From page 9 and every resident must be screened at least once daily with the recommended screening form. Review of the facility's ICPP titled "cohorting" indicated that residents with suspected or confirmed COVID-19 diagnosis must be grouped together within a dedicated area of the facility. Review of this ICPP indicated that the goal of this policy was to minimize the interaction of residents with non- residents. Further review of this ICPP indicated that the staff members assigned to work in the dedicated area with residents must only work in this area and not in other areas where non- residents lived. In an interview with the administrator on at 1:50pm, she stated that since she began working in the facility in her capacity as administrator on , she did not feel that she received adequate orientation or training to perform her duties. In an interview with the administrator on at 2:10pm, she stated that Department of Health (DOH) representatives visited the facility on to review the facility's recent COVID-19 outbreak. She stated that the facility had a total of 7 cottages and she dedicated cottages 4 and 5 to presently maintain all COVID-19 positive residents and all the residents within each of these cottages cohorted and came into physical contact with each other. She stated that remaining cottages 1, 2, 3 and 7 had residents who presently did not have any COVID-19 symptoms and cottage 6 was presently vacant. She stated that there were approximately 17 residents who had tested positive for COVID-19 since the facility began to systematically test the	A 030		

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	AL11964922	A. BUILDING: _____ B. WING _____	12/03/2020

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A 030	Continued From page 10 residents for COVID-19 on . She stated that the DOH representatives who recently visited the facility were not satisfied with the facility's COVID-19 screening processes and other deficiencies which were enumerated as 9 different areas of concerns in a letter DOH provided to the facility and it was dated on . She stated that the facility did not immediately address DOH's concerns relating to areas of concern #3 and 6, which was related to the facility's storage and accessibility to personal protective equipment (PPE) outside of cottages 4 and 5, and staff control and prevention training respectively. In an interview with the Administrator on at 2:29pm, she stated that all staff was trained in control prevention in of 2020 but the staff have not had additional training since then. She stated that since she began her employment in the facility on the staff has not received control and prevention training. In an interview with the director of nursing (DON) on at 2:35pm, she stated that the facility did not meet DOH's area of concern #6 in their letter dated on . She stated that the facility did not presently conduct comprehensive staff training on hygiene, control, personal protective equipment (PPE) donning/doffing and cleaning/ methods. Review of the DOH letter addressed to the facility's administrator on indicated that the facility did not meet several control measures to prevent the spread of COVID-19 which included #3: PPE was not in place outside of facility areas where residents received direct	A 030		

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A 030	Continued From page 11 care, and #6: lack of frequent and continuous staff training on hygiene, control, PPE donning/doffing and cleaning/ methods. Review of the facility's record indicated that on , residents #2, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37 lived in cottage 4 and on , residents #2, 28, 29, 31, 32, 33, 35, 36 and 37 presently lived in cottage 4. Review of the facility records indicated that resident #31 was the first resident that tested positive for COVID-19 immediately after she was hospitalized on . Review of the facility record indicated that the facility tested all of cottage 4 residents for COVID-19 from to and residents #28, 29, 30, 32, 34, 36 and 37 were positive, residents #2, 33 and 35 remained negative and resident #30 was hospitalized on with COVID-19 symptoms. Review of the facility's record indicated that on , residents #16, 18, 19, 20, 21, 22, 23, 24, 25, 26 and 27 lived in cottage 5 and on , residents #16, 18, 24, 25, 26 and 27 presently lived in cottage 5. Review of the facility records indicated that the facility tested all of cottage 5 residents for COVID-19 on and residents #16, 19, 21, 25, and 27 were positive, residents #24 and 26 remained negative and residents #18, 22, 23 and 20 were tested for COVID-19 on , , and respectively and they were positive. Review of the facility records indicated that residents #19, 22 and 23 were hospitalized on , and respectively with COVID-19 symptoms. Review of the facility records indicated that the COVID-19 negative residents who lived on	A 030		

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A 030	Continued From page 12 cottages 4 and 5, remained in their respective cottages while the COVID-19 positive residents also lived in these cottages. In an interview with the administrator on at 11:00am, she stated that resident #31 was the first resident to recently have tested positive for COVID-19 on . She stated that the resident in the facility on and was hospitalized to get evaluated after she and the hospital notified the facility that the resident tested COVID-19 positive on . She stated that the resident was sent from the hospital to the facility on without any COVID-19 symptoms. She stated that the resident was presently in cottage 4 and the facility has not implemented any interventions to clear this resident from isolation precautions or to be placed outside the dedicated COVID-19 area, cottage 4. She stated that the facility has not been in recent communication with the resident's personal physician recently to discuss the resident's COVID-19 diagnosis and her isolation strategy. In an interview with the administrator on at 11:10am, she stated that the facility began to test the residents of cottage 4 for COVID-19 from to since resident #31 had tested positive for COVID-19 in the hospital on . She stated that from to , residents #28, 29, 30, 32, 34,36 and 37 had tested positive for COVID-19 and she ensured that all these residents were confined to cottage 4. In an interview with the administrator on at 11:40am, she stated that resident #23 developed a severe and tested positive for COVID-19 on . She stated that this resident was hospitalized for COVID-19 specific	A 030		

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A 030	Continued From page 13 symptoms, including [redacted] and [redacted] on [redacted]. She stated that this resident lived in cottage 5 and the facility began to test for COVID-19 to the remaining residents of cottage 5 on [redacted]. She stated that residents #16, 18, 19, 20, 21, 22, 25, and 27 had tested positive for COVID-19 and she ensured that all these residents were confined to cottage 5. In an interview with the administrator on [redacted] at 12:30pm, she stated that resident #19 was hospitalized for COVID-19 specific symptoms, including [redacted] and [redacted] on [redacted]. She stated that resident #21 was hospitalized for COVID-19 specific symptoms, including [redacted] and [redacted] on [redacted] and subsequently [redacted] on [redacted] cause due to COVID-19. She stated that resident #30 was hospitalized for COVID-19 specific symptoms, including [redacted] on [redacted]. In an interview with the administrator on [redacted] at 1:10pm, she stated that she believed that the facility did not have any established criteria for the management of COVID-19 residents and necessary interventions to prevent further spread of COVID-19 within the facility. She stated that she was not familiar with the facility policies and procedures titled "Coronavirus/COVID-19 Preparedness and Response Plan". She stated that the facility was not implementing the necessary interventions based on CDC guidelines to prevent the spread of the [redacted] within the facility. In an interview with the administrator on [redacted] at 1:35pm, she stated that the facility did not follow its own policies and procedures relating to the management of COVID-19 residents, including proper cohorting, isolation, screening	A 030		

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A 030	Continued From page 14 and monitoring interventions. In an interview with the DON on at 1:45pm, she stated that she was not sure if facility staff were adequately screening every facility resident for COVID-19. She stated that the facility was not presently maintaining any COVID-19 screening forms in the resident records. In an interview with the administrator on at 9:55am, she stated that resident #31 was readmitted to the facility on with hospice services for . She stated that this resident lived in cottage 4, , and the facility did not conduct a COVID-19 screening when the resident returned to the facility on . Review of the resident's record indicated that the resident was initially admitted on and did not have any COVID-19 screening form or test while she lived in the facility. In an interview with the administrator on at 10:45am, she stated that the facility utilized rapid COVID-19 tests for all the resident testing conducted in and that it was presently arranging for all the facility residents to undergo a "PCR COVID-19" test which was more sensitive. She stated that the facility did not seek consultation from any of the residents' physicians or from DOH relating to the residents living and cohorting within each of the dedicated COVID-19 units, cottages 4 and 5. In an interview with the administrator on at 12:00pm, she stated that after she reviewed the facility's policies and procedures, she understood that cohorting of COVID-19 positive and negative residents within each cottage,	A 030		

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A 030	Continued From page 15 specifically cottage 4 and 5, was not permissible to prevent spread because residents within each cottage did come in physical proximity of each other. She stated that although cottage 6 was vacant and available for placement of resident with 10 individual bedrooms, her staffing was a limiting factor for the facility to move residents into cottage 6. She stated that she did not yet discuss these limitation with her facility leadership and she was presently planning to separate any and all COVID-19 positive residents from the negative residents which lived in cottages 4 and 5. She stated that there were presently 3 COVID-19 negative residents who lived in cottage 4 (residents #2, 33 and 34) and 2 COVID-19 negative residents who lived in cottage 5 (residents #24 and 26). She stated that these COVID-19 negative residents must have been moved immediately upon determining the other residents in their respective cottages were COVID-19 positive so to prevent further spread. She stated that the facility attempted to keep cottage 6 open to place COVID-19 negative residents there on , but she did not have staff available to work in cottage 6 to continue using this area. She stated that she was responsible to ensure that the facility policies and procedures were implemented and followed by all the staff members and to staff the facility according to the needs of the residents. She stated that the facility began screening its staff for COVID-19 after DOH came onsite on . In an interview with the administrator on at 1:05pm, she stated that the facility medication technicians and nurses presently went from non-COVID-19 cottages (cottages 1, 2, 3, 4 and 7) to COVID-19 positive cottages 4 and 5 throughout their shifts with using proper PPE.	A 030		

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A 030	Continued From page 16 In an interview with the administrator on at 1:30pm, she stated that before any resident was determined to have COVID-19 in the facility, staff member D tested positive for COVID-19 on . She stated that staff D was tested at her other job on and the staff member reported to the facility that this test came as positive this same day. She stated that the facility did not test all of its staff members for COVID-19 and it intended on doing this within the next week. In an interview with staff member D on at 2:10pm, she stated that she worked in the facility as a caregiver and provided direct resident care. She stated that the she also worked at another local assisted living facility and she was tested there with a rapid COVID-19 test on . She stated that she notified the facility the same ( ) day of her positive COVID-19 status and that she was not certain of how she COVID-19, but she did not develop any symptoms. She stated that she worked in the facility's cottage 4 and provided direct resident care on , , 20 and , and she was told by the administrator to not come to work on and until she was cleared to not have COVID-19. On , observations were made of Staff J and Staff N, whose responsibilities included assisting residents with their self-administration of medications in the facility's two COVID-19 designated units, Cottages 4 and Cottage 5. Staff J was observed assisting Resident #16 with his medications on at 10:20 AM in Cottage 5, and assisting Resident #17 with her medications in Cottage 7. Staff N was observed assisting Resident #2 with her medications on at 9:15 AM Cottage 4, and assisting Resident #3 with her medications at 1:05 PM in	A 030		

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A 030	Continued From page 17 Cottage 2. During these observations, staff members J and N wore the same N95 mask and did not clean each of their . . . . shields when going between cottages. This presented to have an increased potential for cross-contamination between the COVID-19 positive units, cottages 4 and 5, and the non-positive units, cottages 2 and 7. In an interview conducted on at 10:27 AM, Staff N provided the following information: She assists residents with medications mostly in Cottages 1, 2 and 4 (a COVID-19 positive unit), but assists in other cottages as well. In a telephone interview conducted on at 10:39 AM, Staff J provided the following information: She assists residents with medications in Cottages 3, 5 (a COVID-19 positive unit) and 7. She goes to Cottage 5 around 8:00 AM, 12:00 PM and 1:00 PM daily. She uses a personal cloth cover that she wears throughout her shift. She wears the same N95 mask throughout her shift unless it gets wet or soiled. In an interview with the Administrator on at 10:27 AM she stated all known COVID-19 positive residents were in Cottages #4 and #5 and the recent COVID-19 cases for residents in the facility started on . . and progressed thru cottage 4 and eventually to cottage 5 on or about . . . . She stated she didn't move the identified COVID-19 negative residents from cottages 4 and 5 because she believed that most of these COVID-19 negative residents were previously COVID-19 positive and it was permissible for these COVID-19 negative residents to cohort within COVID-19 positive residents in cottages 4 and 5 without risk of	A 030		

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A 030	Continued From page 18 further COVID-19 spread. She stated that she did not consult with DOH or any of the individual residents' physicians to ensure that cohorting these residents in cottages 4 and 5 was optimal to prevent COVID-19 spread within the community. She stated that she was not familiar with the specific facility policies and procedures relating to the cohorting of COVID-19 positive with negative residents within the dedicated COVID-19 areas, cottages 4 and 5. In an interview conducted on at 11:42 AM, the Administrator and DON stated Medication Technicians are required to don a N95 mask along with a surgical mask, and a shield prior to entering the COVID-19 positive units. Prior to exiting the unit, they are required to clean and sanitize the shield and remove and properly dispose of the surgical mask. Review of the facility's employee screening forms on at 10:43am, indicated that the facility did not have any employee screening forms performed of its employees before . Further review of the facility's employee screening forms indicated the following: - On at 8:10pm, staff U was screened by Staff T and staff U's temperature was not recorded in this form. - On at 3:00pm, staff V was screened by Staff T and staff V's information relating to questions #1 and 3 was not completed or it was omitted. - On at 3:00pm, staff V was screened by Staff M and staff V's form was not completed and it did not include this staff member's temperature reading. - On at 11:50 PM Staff M's screening form did not included this staff member's	A 030		

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A 030	Continued From page 19 temperature reading. - On Staff W's screening form indicated that this staff member completed this screening by herself and it was not checked by another staff member. - On at 8:45 PM a facility Visitor screening form did not include the staff member conducting this screen. - On at 12:55, Staff X's temperature was not recorded and the actual time of day (AM/PM) was not indicated in the form. - On Staff X's screen indicated that there was no time, Screener Name or Screener Signature indicated on the form. - Staff Y completed an Employee Daily Screening form and there was no date, time, Screener Name or Screener signature indicated on the form. - On at 10:53 PM, Staff Y was screened and no Screener name or Signature is indicated on the form. - On at 10:25 a Visitor was screened by staff M and it indicated that the visitor's temperature reading required her to go to Check #3, however, this was not completed. Further review indicated that no other entries were made in Check #4, Check #5 and Check #6. - On Staff Z was screened by Staff T and it indicated that the time of screening was not entered on the form. - On at 6:00 PM Staff M was screened by herself and not another staff member. - On at 9:40 AM, AHCA Surveyor was screened and the Screener's Name and Signature was not entered on the form. - A , , Assistant completed a Visitor Screening Tool form and revealed the date, time of screening, Name of Screener and Signature of Screener is not indicated on the	A 030		

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A 030	Continued From page 20 form. - A Hospice Nurse presented at the facility to see a Resident and completed the Visitor Screening Tool. The date, time of Screening, Name of Screener and Signature of Screener is not indicated on both forms. - A Visitor completed a Visitor Screening Tool. The date, time, Name of Screener and Signature of screener was not indicated on the form. Class III	A 030		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. [illegible], 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance [illegible], 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health	A 162		

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A 162	Continued From page 21 care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually. (g) 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 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for Optional State	A 162		

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A 162	Continued From page 22 Supplementation (. . .), CF-ES 1006, ... , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , , ... of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's . . . . . , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.	A 162		

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 _____	12/03/2020

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 162	Continued From page 23 (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to maintain resident records as required for 2 of 2 sampled Residents (#1, 2) by not maintaining pertinent medical records for residents who previously and currently reside at the facility. The facility also failed to provide requested records or documents related to staffing and required screenings. The findings included: Review of resident records was conducted throughout the survey from through . A number of focused reviews were impeded due to the lack of availability of resident records. The following concerns were identified: Review of Resident #2's records revealed she was admitted on ; she stills resides at the facility. During review of her records, it was noted there were no medication observation	A 162		

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A 162	Continued From page 24 records prior to . . . . The resident observation notes began (about nine months after admission) and ended on . . . . . (about three weeks prior to the survey). This impeded a review of allegations of issues with medication and new onset of received from a State Agency that occurred in . . . . . . Review of Resident #1's records revealed he was admitted to the facility on . He , . . . , on . . . . . During review of his records, it was noted there were no resident observation notes prior to . . . . . (eight months after admission). This impeded a review of allegations of new history of . . . and lack of supervision received from a State Agency that occurred in . . . . . . I an interview with the facility's Director of Nursing (DON) on at 1:10 PM, a request was made for documentation related to the residents being reviewed. The information was not provided. On . . . . . at 12:52 PM, Staff N, a Medication Technician who also assists with resident records was asked for the needed resident records. On . . . . . at 1:56 PM, a follow-up request was made to Staff N. The DON was present at the time and made suggestions for where Staff N should look for the requested records. She stated she believes staff have maintained regular resident notes. In an interview with the Administrator on at 9:10 AM a follow-up request for the needed resident records was made. She stated she was aware of the situation with the resident records and they were not having any success locating	A 162		

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A 162	Continued From page 25 the records. She acknowledged the facility's lack of maintaining documentation was deficient practice. . . . . . at 10:43 AM a request was made to Staff A for all the Employee and Visitor screening forms beginning the . . . . . through the end of . She provided a binder containing Staff screening forms and stated it concluded the forms for all staff and all cottages. Review of the forms provided revealed a beginning dated of and did not include the month of . . . . . . In an interview with the Administrator On at 11:13 AM she was informed that the requested Employee and Visitor Screening forms received from Staff A has a starting date of . . . . . and requested again the Screening forms beginning through . She said she would get them. The information was not provided prior to the Exit Interview and has not been received to date. In an interview with the Administrator on at 4:34 PM a request was made to for the Home Health Agency staffing visits indicating the dates, shifts, cottages and residents to whom care was provided by them. The information was not provided prior to the Exit Interview and has not been received to date. On . . . . . at 4:36 PM a request was made to the Administrator for a list containing all staff names, positions and contact information that was employed with the facility from through . . . . . The Administrator acknowledged the request and stated she would provide it. The information was not provided prior to the Exit Interview and has not been received to	A 162		

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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A 162	Continued From page 26 date. On ..... at 10:47 AM, a follow-up inquiry was made to Staff N, she stated nothing more was found/or provided. Class III	A 162		