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 _____ | 03/10/2021 |

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| PACIFICA SENIOR LIVING OF PALM BEACH | 4760 JOG ROAD GREENACRES, FL 33467 |

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| CZ813 | 59A-35.090(3)(c), FAC Results of Screening & Notification In File<br><br>59A-35.090 Background Screening.<br>(3) Results of Screening and Notification.<br>(c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure 1 out of 4 staff member's, Staff A, had eligibility results of Background Screening (BGS) available for review.<br><br>The findings included:<br><br>Review of Staff A's employee record revealed a date of hire on in the position of a Medication Technician who provides direct resident care. Further review of the employee record revealed there was no documentation to validate Staff A had passed her BGS and was eligible to work in the facility in her capacity as a Medication Technician.<br><br>In an interview with the Administrator on at 2:45 PM, she stated the facility did not have a copy of Staff A's most recent BGS results to validate her eligibility to work in the facility.<br><br>Unclassified | CZ813 | | |
| CZ830 | 408.821 FS Emergency Management Planning<br><br>408.821 Emergency management planning; emergency operations; inactive license.-<br>(1) A licensee required by authorizing statutes and agency rule to have a comprehensive | CZ830 | | |

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| CZ830 | Continued From page 1<br><br>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:<br>(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.<br>(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.<br>(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.<br>(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.<br>(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.<br>(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:<br>1. Suffered damage to its operation during the | CZ830 | | |

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| CZ830 | Continued From page 2<br><br>state of emergency.<br>2. Is currently licensed.<br>3. Does not have a provisional license.<br>4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.<br>(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.<br>(4) The agency may adopt rules relating to emergency management planning, communications, and operations. Licensees 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, | CZ830 | | |

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| CZ830 | Continued From page 3<br><br>planning, or operations.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure their Comprehensive Emergency Management Plan (CEMP) was up-to-date and approved by the Local County Emergency Management Division.<br><br>The findings included:<br><br>On and a Relicensure Survey was conducted at the facility. During an interview with the Administrator on at 10:08 AM, a request was made for the facility's current CEMP approval letter. The Administrator stated their CEMP was out of date. She stated she had not had a chance to touch it and it was way out of date. A request was made to provide all communications and submissions she had regarding their CEMP.<br><br>Review of the facility CEMP binder provided on , revealed a CEMP letter from the Local Emergency Management Division dated with an approval through and expiry on . Further review of documents contained in the binder indicated the facility submitted a CEMP renewal request which was reviewed by the Local County Emergency Management Division on and rejected. No subsequent resubmissions of the CEMP to the County were provided during the survey.<br><br>On at 5:05 PM, an exit conference was conducted with the Administrator who confirmed their CEMP was expired and the facility had not resubmitted the requested CEMP corrections for review to the Local Emergency | CZ830 | | |

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| CZ830 | Continued From page 4<br>Management Division.<br><br>Unclassified | CZ830 | | |

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| A 000 | Initial Comments<br><br>An unannounced Relicensure with Extended Congregate Care (ECC), Focused . . . . Control and Generator Monitoring survey was conducted on . . . . . through . . . . . at Pacifica Senior Living of Palm Beach. The facility had deficiencies at the time of the survey. | A 000 | | |
| A 025 | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(7) The facility shall 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 must notify the resident ' s representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.<br><br>59A-36.007<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: | A 025 | | |

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| A 025 | Continued From page 1<br><br>(a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C.<br>(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.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(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.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to provide appropriate personal supervision of care and daily observation to ensure the general health, safety and well-being, for 1 out of 3 sampled residents (Resident #1).<br><br>The findings included:<br><br>Review of the facility Elopement Response policies and procedures dated on , indicated that elopement precautions must be applied to all its residents and residents must be | A 025 | | |

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| A 025 | Continued From page 2<br><br>assessed for elopement risk upon admission. Further review of this document indicated in the event of a resident elopement, the facility must have the resident be examined by a Physician and reevaluated by the facility for appropriateness once the resident was located.<br><br>Review of the facility Elopement Response policies and procedures dated on . . . , indicated elopement precautions must be applied to its residents who have attempted to elope and residents with history of elopement. Review of this document indicated all residents with an assessed risk for elopement or with history of elopement must be identified so the facility staff can be aware of each resident's supervision and care needs. Review of this document indicated each resident with a diagnosis of or a history of elopement must receive a Physician's statement regarding that resident's ability to leave the facility without supervision. Review of this document indicated the facility must ensure each resident with a high risk for elopement have on their person a facility business card and personal identification which included the resident's name, facility's name, address and telephone number. Review of this document indicated facility staff must be aware of each elopement risk resident's location at all times. Further review of this document indicated in the event of a resident elopement, the facility must have the resident reevaluated to determine the resident's appropriateness in the facility and the resident's Service Plan must be updated with immediate steps by the facility to prevent further elopements by the resident.<br><br>Review of the facility records indicated Resident #1 was found missing from the facility on at approximately 5:20 PM. Further | A 025 | | |

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| A 025 | Continued From page 3<br><br>review of the facility records indicated the resident was found by the facility nurse approximately a mile from the facility property and the resident was returned safely to the facility on at approximately 6:00 PM.<br><br>On at approximately 2:25 PM, an interview was conducted with Resident #1. Resident #1 was lucid upon interview however showed signs of memory loss. When an inquiry was made about the events that occurred on , Resident #1could not remember or verbalize anything about the elopement.<br><br>Review of the facility written Narrative of the Circumstances of the Elopement document dated , states 'The resident was found by LPN (Licensed Practical Nurse) approximately mile from the facility, lost and looking for help to find her way to the facility.'<br><br>Review of Resident #1's Form 1823 Health Assessment dated , indicated she was diagnosed with , and memory loss. Review of this Health Assessment indicated the resident needed assistance with bathing, , grooming, toileting and transferring and she was independent with ambulation and eating. Further review of this Health Assessment indicated the Elopement Risk Examination for this resident was not completed. Review of the resident's Progress Notes from to indicated the resident did not receive a Physician evaluation to determine the resident's current elopement risk. Review of Resident #1's Service Plan dated , completed 6 days after the elopement, indicated the resident ambulated independently | A 025 | | |

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| A 025 | Continued From page 4 | A 025 | | |

with a steady gait and she was an elopement risk. Review of this Service Plan indicated the resident's elopement will be identified, facility procedures must be followed, staff will be updated on the facility's elopement response policies and to identify and implement proper exit-seeking interventions for the resident. Further review of this Service Plan indicated there were no resident-specific elopement prevention interventions listed, there was no Service Plan meeting summary documented and there were no Physician, Nurse, resident or family member signatures to represent that this Service Plan was reviewed with these individuals.

Review of the facility's Resident Service Plan summaries dated from to indicated there were 16 residents who had updated Service Plan and 3 of these residents presented to be at high risk of and with a history of elopement. Review of this document indicated that Resident #1 was identified with elopement as a need/problem and there were no specific interventions to be implemented by the facility to prevent a reoccurrence of elopement. On , the facility census was identified to be 75 with a capacity of 98.

In an interview conducted with the Administrator on at 11:20 AM, she stated that Resident #1 went missing from the access-controlled Cottage 7 on at around 5:20 PM, the nurse found the resident about a mile from the facility and the resident was at the facility within 30 minutes from when she was discovered missing. She stated the resident was looked over by the nurse and the resident was not physically injured.

In an interview conducted with the Administrator

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| A 025 | Continued From page 5<br><br>on . . . . . at 2:00 PM, she stated the facility did not ensure Resident #1 received a Physician examination immediately after the resident eloped and returned to the facility on . She stated the resident was also not completely reevaluated by the facility after the resident eloped and returned to the facility on . . . . . . . She stated she understood the facility's elopement policies and procedures required in the event of a resident elopement, the facility must reevaluate every resident's elopement risk, including a Physician consultation, so the facility can implement additional safety and elopement prevention measures.<br><br>In an interview conducted with Resident #1's family member on . . . . . at 2:10 PM, he stated the facility informed him on Resident #1 went missing for about 30 minutes and the resident was found by facility staff without injury. He stated he was not aware Resident #1 departed or eloped from the facility because the facility did not give him details of this event on . He stated he was also not informed the resident needed to be reevaluated for elopement risk by the facility to ensure the resident's continued safety.<br><br>In an interview conducted with the facility's new Administrator on at 10:30 AM, she stated the previous Administrator during this Agency inspection on was no longer employed by the facility effective on . . . . . and she was presently serving the facility as the new Administrator effective . . . . . . She stated the former Administrator previously provided to the Agency outdated resident elopement policies and procedures and she ensured the updated policies and procedures dated . . . . . will be provided to the Agency for this inspection. She stated she | A 025 | | |

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| A 025 | Continued From page 6<br><br>was aware of Resident #1's elopement on despite not being in the facility on the day when this happened. She stated the facility provided all its residents with "Memory Care" which was an elevated level of care which included secured courtyard areas and continual supervision of care by the staff to ensure each resident's health care needs were met. She stated this all-inclusive level of care treated every resident in the facility as an elopement risk, with further attention given to residents with a higher risk for elopement once elopement history is identified and a Physician deemed a resident with an elopement risk based on their clinical condition.<br><br>In an interview conducted with the facility's new Administrator on at 10:40 AM, she stated Resident #1 has not recently received a Physician evaluation to determine her elopement risk because the resident's transportation plans to go to the physician's office on were not adequately arranged. She stated the facility left a voice mail message for the resident's family member to transport the resident on to the Physician's office and the facility did not receive confirmation the resident's transportation was secured for this Physician . She stated that although the facility provided transportation services for resident medical , this transportation service was not offered to the resident for this resident's Physician on . She stated she did not review the resident's agreement dated to ascertain the resident's transportation services options.<br><br>In an interview conducted with the facility's new Administrator on at 10:45 AM, she stated Resident #1 was assessed by the facility's | A 025 | | |

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| A 025 | Continued From page 7<br><br>Consultant Nurse on . . . . to be at a high risk for elopement and the resident needed further evaluation from the Physician to determine the resident's clinical elopement status. She stated the resident's Service Plan completed by the Consultant Nurse on was not shared or reviewed with the resident or the resident's family member. She stated the facility was not presently following its elopement prevention policies and procedures relating to Resident #1 since the facility did not ensure that the residents' Health Assessment dated on had a complete elopement risk evaluation from the Physician and the resident did not receive a Physician re-evaluation with a statement regarding the residents' ability to leave the facility without supervision after the elopement on . She stated the facility must have this Physician re-evaluation to determine the resident's appropriateness in the facility and to have the resident's Service Plan updated with immediate steps to prevent further elopements by the resident. She stated the facility also was not presently ensuring that Resident #1 continually had on her person, a facility business card and personal identification as per the policies and procedures. She stated the facility did not know how Resident #1 eloped on , did not complete a Quality Assurance review of this event and the direct care staff were presently monitoring the resident every hour, however this was not being documented to ensure compliance. She stated the facility also did not conduct elopement-specific evaluations on all of its residents.<br><br>In an interview conducted with Caregiver F on at 12:00 PM, who was presently working in Cottage 7, she stated she was aware that Resident #1 eloped because the resident | A 025 | | |

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asked her before to go outside of cottage 7, which was the cottage where the resident resided. She stated she also was aware of 2 other residents in this cottage who were high risk for elopement, but she could not explain the interventions she needed to implement which related to these residents' high elopement risk status. She stated there were no resident-specific records in Cottage 7 for her to review the residents' elopement status or any additional interventions she needed to follow for these residents.

In an interview conducted with Caregiver G on [redacted] at 12:25 PM, who was presently working in Cottage 3, she stated that she was aware of one resident in this cottage who was high risk for elopement but she could not explain the interventions she needed to implement which related to this resident's high elopement risk status. She stated that there were no resident-specific records in Cottage 3 for her to review the resident's elopement status or any additional interventions she needed to follow for the resident.

In an interview conducted with Caregiver H on [redacted] at 12:25 PM, who was presently working in Cottage 2, she stated she was aware of one resident in this cottage who was high risk for elopement but she could not explain the interventions she needed to implement which related to this resident's high elopement risk status. She stated there were no resident-specific records in Cottage 2 for her to review the resident's elopement status or any additional interventions she needed to follow for the resident.

In an interview conducted with the Consultant

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Nurse on . . . . . at 12:55 PM, she stated she was present on when the Administrator alerted her Resident #1 had eloped from the facility. She stated she was notified of this on . . . . . at around 5:05 PM and she immediately responded by going to Cottage 7 to speak with the staff about this event. She stated the staff confirmed the resident was missing, and they looked around Cottage 7 and adjacent Cottage 6 for the resident, and they did not find the resident. She stated on . . . . . at around 5:15 PM, she began walking outside of the facility on the sidewalk, northbound on the east side of Jog Road until she reached the commercial plaza located just north of the facility property. She stated she observed the perimeter area between this plaza and the facility at this time and didn't find the resident. She stated she proceeded to walk on the sidewalk, eastbound on the south side of Melaleuca Lane, which was the roadway at the closest intersection to the north of the facility, which was less than a mile from the facility. She stated she walked past the plaza into the residential development immediately next to the plaza and she saw Resident #1 walking towards her on the sidewalk. She stated on . . . . . at around 5:30 PM, she asked Resident #1 her name and confirmed it was indeed the resident who eloped from the facility. She stated the resident and her then walked to the facility and the resident was lucid, yet slightly . . . . . , and didn't know how she got to where she was. She stated she arrived at the facility with the resident about 5 minutes later and she performed a visual assessment. She stated the resident didn't have any injuries or , and she didn't document her visual nursing assessment for the resident's record. She stated when she returned to the facility with the resident on . . . . . , the Administrator then took the resident to her

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| A 025 | Continued From page 10 | A 025 | | |

cottage and she didn't follow this case any further. She stated she didn't review the residents' Health Assessment or didn't find out if there was a completed elopement evaluation done for the resident. She stated it was the expectation the facility follow its' policies and procedures regarding the complete care of Resident #1 and all other residents in the facility.

In an observation conducted on at 1:20 PM, there was an unobstructed sidewalk leading outside of the facility, located on the east side of Jog Road. During this observation on a northbound direction, this sidewalk led to an eastbound turn on Melaleuca Lane which then led towards the first residential development just passing the commercial plaza immediately to the north of the facility property. During this observation, the measured distance of this path was approximately a mile from the facility property entrance.

In an interview conducted with Caregiver I on at 1:35 PM, she stated she last saw Resident #1 on at approximately 4:15 PM. She stated at this time, the resident was walking outside Cottage 7, in the secured courtyard and she then took care of some residents until about 5:00 PM, then she didn't see Resident #1 in the dining room for dinner. She stated she asked another Caregiver if Resident #1 was seen, and the response from this Caregiver was she did not see the resident. She stated immediately after this, she went outside the Cottage 7 and adjacent Cottage 6 to look for the resident, but she didn't see the resident. She stated she immediately notified the Administrator and the Supervisor took over the search. She stated she didn't know Resident #1's elopement status or if the Physician evaluated the resident to

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| A 025 | Continued From page 11<br>be at high risk for elopement before . .<br><br>As of . . . . . , Resident #1 eloped 28 days prior on . In an interview conducted with the new Administrator on . . . . . at 2:35 PM, she stated she thought the cottage gates received a full professional assessment in order to eliminate the possibility of _, but this has not been completed yet. She further stated, they are now in the process of getting a contractor to assess the gates, conduct trainings, assess all residents and other items as per the facility Policies and Procedures.<br><br>Class III | A 025 | | |
| A 056 | 59A-36.008(7) FAC Medication - Labeling and Orders<br><br>(7) MEDICATION LABELING AND ORDERS.<br>(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:<br>1. The resident's name; and,<br>2. The identification of each medicinal drug in the container.<br>(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 another.<br>(c) If the directions for use are "as needed" or "as | A 056 | | |

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| A 056 | Continued From page 12 | A 056 | | |

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 or refilled in a timely manner.
(g) Pursuant to section 465.0276(5), F.S., and

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| A 056 | Continued From page 13<br><br>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:<br>1. Practitioner's name,<br>2. Resident's name,<br>3. Date dispensed,<br>4. Name and strength of the drug,<br>5. Directions for use; and,<br>6. Expiration date.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure resident medications were available for 1 of 6 sampled residents reviewed for medications, Resident #4.<br><br>The findings included:<br><br>Review of Resident #4's Medication Observation Record (MOR) dated to revealed the resident did not receive her (for circulation), (for ), (for ), (for ), (for ) and (for ) oral medications on and . Review of the resident's record | A 056 | | |

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| A 056 | Continued From page 14<br><br>revealed no documentation of Physician notification the resident did not receive these medications on [redacted] and [redacted]. Further review of the resident's MOR documented the facility was awaiting delivery of the resident's medications on and from the pharmacy.<br><br>In an interview conducted with Staff B on at 9:30 AM, she stated she was not able to provide the [redacted] and medications for Resident #4 this morning because these were not yet delivered by the pharmacy. She stated whenever medications arrive from the pharmacy, the nurses place them in the nursing station so she may deliver the medications to the residents. She stated she will check again if Resident #4's medications were received by the facility at this time.<br><br>In an interview conducted with the Consultant Nurse on [redacted] at 9:40 AM, she stated Resident #4's [redacted] and [redacted] medications were located in the facility's reception area and will be delivered to the resident immediately. She stated she was in process of communicating with the resident's Physician to ensure there were no new orders due to the resident not receiving these medications on [redacted] and [redacted]. In an interview conducted with the Nurse Consultant on [redacted] at 11:05 AM, she stated there were no changes with the resident's medications, except for a substitution for the resident to receive the [redacted] medication at bed time instead of in the morning.<br><br>In an interview conducted with the Administrator on at 4:00 PM, she stated Resident #4's | A 056 | | |

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| A 056 | Continued From page 15<br><br>medications were delivered by the pharmacy and received by the facility's reception on and these were immediately routed to the nursing station after the facility received them. She stated that since these medications were placed in the copy room next to the reception area and not signed and picked up by a nurse, this prevented the facility from providing these medications to the resident in a timely manner.<br><br>Class III | A 056 | | |
| A 078 | 59A-36.010(2) FAC Staffing Standards - Staff<br><br>(2) STAFF.<br>(a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership.<br>1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of .<br>2. If any staff member has, or is suspected of | A 078 | | |

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| A 078 | Continued From page 16<br><br>having, a communicable . . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable .<br><br>(b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter.<br>(c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C.<br>(d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents.<br>(e) For facilities with a licensed capacity of 17 or more residents, the facility must:<br>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,<br>2. Maintain time sheets for all staff.<br>(f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.<br><br>This Statute or Rule is not met as evidenced by: | A 078 | | |

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| A 078 | Continued From page 17<br><br>Based on record review and interview, the facility failed to provide documented evidence of annually updated negative { } examinations for 3 out of 4 staff members, Nurse B, Staff B and Staff D.<br><br>The findings included:<br><br>Review of Nurse B's employee record revealed she was hired on and she provides direct resident care. Further review of the employee record revealed no documentation of an annual negative examination.<br><br>Review of Staff B's employee record revealed she was hired on and she provides direct resident care. Further review of the employee record revealed Staff B had a " and health care provider statement" form dated on , however it did not have a health care provider signature on it. Further review revealed no documentation of an annual negative examination.<br><br>Review of Staff D's employee record revealed she was hired on and she provides direct resident care.<br>Further review of Staff D's employee record revealed a facility form titled Free From Communicable dated documenting Staff D's negative Status. No additional forms were available for review documenting Staff D's annual negative examination.<br><br>In an interview conducted with the Administrator on at 2:35 PM, she stated she was aware the facility must ensure all direct care staff members possess documented evidence of an annually updated negative examination to | A 078 | | |

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| A 078 | Continued From page 18<br>work in their capacity.<br><br>Class III | A 078 | | |
| A 082 | 59A-36.011(4) FAC Training - / .<br><br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interview and record review it was determined the facility failed to ensure that 2 of 2 Staff employee records reviewed contained the required / . . training, for the Administrator and Staff D.<br><br>The findings included:<br><br>Review of the Administrator's employee record revealed a date of hire of . . . . . . The Administrator has direct contact and interaction with residents. Further review revealed no documentation of the required / . training.<br><br>Review of Staff D's employee record revealed a date of hire of . . . . . Staff D has direct contact with and provides direct care to residents. Further review revealed no documentation of the | A 082 | | |

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| A 082 | Continued From page 19<br>required / . . training.<br><br>In an interview conducted with the Administrator on at 1:48 PM, she confirmed she could not locate documentation of this training for herself or Staff D.<br><br>Class III | A 082 | | |
| A 083 | 59A-36.011(5) FAC Training - First Aid and<br><br>(5) FIRST AID AND . . . . . ( . . ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times.<br>(a) Documentation that the staff member possess current . certification that requires the student to demonstrate, in person, that he or she is able to perform . and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement.<br>(b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on employee record review and interview, the facility failed to ensure 1 of 2 employee records reviewed had a current valid card of | A 083 | | |

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| A 083 | Continued From page 20<br>completion for First Aid and for Staff D.<br><br>The findings included:<br><br>Review of the employee record for Staff D revealed a date of hire of to provide direct resident care services on the 11:00 PM to 7:00 AM shift.<br><br>In an interview conducted with the Administrator on at 3:47 PM, the Administrator was advised Staff D's record did not contain documentation of completion of training in First Aid and . The Administrator was further advised a staff member holding certification in First Aid and must always be present in the facility. A request was made for a list of employees who work the 11:00 PM-7:00 AM shift.<br><br>In an interview conducted with the Administrator on at 4:15 PM, she stated she was not able to locate documentation for a staff member working the 11:00 PM - 7:00 AM shift. No additional information was forthcoming.<br><br>Class III | A 083 | | |
| A 084 | 59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt<br><br>59A-36.011<br>(6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses | A 084 | | |

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| | AL11964922 | A. BUILDING: _____ B. WING _____ | 03/10/2021 |

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| PACIFICA SENIOR LIVING OF PALM BEACH | 4760 JOG ROAD GREENACRES, FL 33467 |

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| A 084 | Continued From page 21<br>provided in fulfilment of this requirement must meet the following criteria:<br>(a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for [illegible] control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance.<br>(b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to:<br>1. Read and understand a prescription label;<br>2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including:<br>a. Assist with oral dosage forms, [illegible] dosage forms, and [illegible] and [illegible] dosage forms;<br>b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;<br>c. Recognize the need to obtain clarification of an "as needed" prescription order; | A 084 | | |

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| A 084 | Continued From page 22<br>d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders;<br>e. Complete a medication observation record;<br>f. Retrieve and store medication;<br>g. Recognize the general signs of adverse reactions to medications and report such reactions;<br>h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection;<br>i. Assist with ;<br>j. Use a to perform testing;<br>k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels;<br>l. Apply and remove stockings and hosiery;<br>m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and,<br>n. Measurement of , rate, temperature, and , rate.<br>(c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted | A 084 | | |

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| A 084 | Continued From page 23<br><br>living facility. The 2 hours of continuing education training may be provided online.<br>(d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n.<br><br>429.52<br>(6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training<br><br>This Statute or Rule is not met as evidenced by:<br>Based on employee record review and interview, the facility failed to provide evidence of medication management training for 1 of 3 staff member employee records reviewed, Staff B.<br><br>The findings included:<br><br>Review of Staff B's employee record revealed a hire date of as a Caregiver and Medication Technician who provides assistance with self-administration of medications. Further review revealed there was no other documentation available for review that Staff B has received any medication management training. | A 084 | | |

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| A 084 | Continued From page 24<br><br>In an interview conducted with the Administrator on [redacted] at 2:40 PM, she stated Staff B worked as a Caregiver and Medication Technician and confirmed there was no documentation to review that Staff B received an initial 6 hours or 2 hour annually updated medication training. She stated she was aware the facility must ensure all staff who provide assistance with self-administration of medications possess this medication management training to work in that capacity.<br><br>Class III | A 084 | | |
| AE200 | 59A-36.021(1); 429.07(3)(b)4 ECC - Licensing<br><br>59A-36.021(1) LICENSING.<br>(a) Any facility intending to establish extended congregate care services must obtain a license from the agency before accepting residents needing extended congregate care services.<br>(b) Only the portion of a facility that meets the physical requirements of subsection (3), and is staffed in accordance with subsection (4), is considered licensed to provide extended congregate care services to residents who meet the admission and continued residency requirements of this rule.<br><br>429.07(3)(b)<br>4. A facility that is licensed to provide extended congregate care services must:<br>a. Demonstrate the capability to meet unanticipated resident service needs.<br>b. Offer a physical environment that promotes a homelike setting, provides for resident privacy, promotes resident independence, and allows sufficient congregate space as defined by rule. | AE200 | | |

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| AE200 | Continued From page 25<br><br>c. Have sufficient staff available, taking into account the physical plant and fire safety features of the building, to assist with the evacuation of residents in an emergency.<br>d. Adopt and follow policies and procedures that maximize resident independence, dignity, choice, and decision making to permit residents to age in place, so that moves due to changes in functional status are minimized or . . . . . .<br>e. Allow residents or, if applicable, a resident's representative, designee, surrogate, guardian, or attorney in fact to make a variety of personal choices, participate in developing service plans, and share responsibility in decision making.<br>f. Implement the concept of managed risk.<br>g. Provide, directly or through contract, the services of a person licensed under part I of chapter 464.<br>h. In addition to the training mandated in s. 429.52, provide specialized training as defined by rule for facility staff.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to establish extended congregate care (ECC) policies for residents who may meet the admission and continued residency requirements for this license.<br><br>The findings included:<br><br>Review of the facility records indicated the facility did not have any Policies and Procedures to describe the admission, services, continued residency and discharge requirements for residents who required ECC services. Further review of the facility records additionally indicated there were no staff members who received any recent ECC training. | AE200 | | |

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| AE200 | Continued From page 26<br><br>In an interview conducted with the Administrator on at 2:45 PM, she stated even though the facility was presently licensed to provide ECC services to all of its resident beds, the facility did not presently provide any ECC services to any of its residents therefore did not have any policies. She stated the facility was presently in the process to withdraw it's ECC licensure because the facility did not offer these services for several years, it did not intend to provide ECC services and it was not a necessary license for the facility to have. She reiterated the facility did not have any ECC policies and procedures in place and it did not presently ensure that its staff members had the required ECC training, because it was no longer implementing ECC services to the residents.<br><br>Review of the facilities Health Care Licensing Application for Assisted Living Facility - Renewal Licensure document, revealed the Administrator submitted their request for a Standard Relicensure with Extended Congregate Care (ECC) for 98 beds for the entire building and all resident rooms. This relicensure with ECC request was submitted to the State Agency on for review.<br><br>Class III | AE200 | | |