Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964870	A. BUILDING: _____ B. WING _____	05/20/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced focused control and complaint survey for #2021002909 was conducted from through , at Pacifica Senior Living Fort Myers, an assisted living facility in Fort Myers, Florida. Complaint #2021002909 contained 2 allegations of which 1 was substantiated with related citation. The following is a description of the deficiency.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (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. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents	A 025		

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A 025	Continued From page 1 accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to document notification/notify the family or responsible party when significant changes for occurred for 3 (Residents #1, #4, and #5) of 5 residents and failed to document behavioral changes for 1 (Resident #1) of 5 residents reviewed for significant changes. The findings included:	A 025		

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A 025	Continued From page 2 1. A review of Resident #4's record revealed a Narrative Charting note date [redacted] at 11:02 a.m. topic "Change in behavior. Care givers report resident has been walking around crying lately, resident cannot voice what is wrong where I understand her, this nurse has reached out to [redacted] Physician Assistant (PA) awaiting response on what to do for resident." Interview on [redacted] at 10:40 a.m., the Resident Services Director ([redacted]) confirmed the Licensed Practical Nurse (LPN) Staff A wrote on [redacted] that Resident #4 had increased crying, wanted more attention from staff, which was a significant change in her behaviors. The [redacted] verified they notified [redacted] PA-B as noted in the record. She stated she thinks [redacted] PA-B came in the next day to see the resident but confirmed [redacted] PA-B did make a change in the resident's medication. She said the Power of Attorney (POA) is the facility's contact for any changes in the resident condition. The RDS confirmed there was no documentation in the medical record they had notified the POA related to the behavioral changes noted on [redacted]. The [redacted] said she thinks the [redacted] PA-B had seen/assessed the resident the next day, but she doesn't know because the [redacted] PA-B doesn't send her progress notes to the facility. She knows the [redacted] PA-B had ordered [redacted] 15mg but doesn't know why the [redacted] PA-B had ordered that medication to treat which behavior. 2. A review of Resident #5's record revealed a Narrative Charting note on [redacted] topic: behavior, (medical practitioner) advised [redacted] that resident made a comment "I want to kill myself" and asked if she had a plan, etc. and resident	A 025		

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A 025	Continued From page 3 would not discuss further. made PA-B aware. There is no notation/documentation in the medical record the facility had notified the POA about Resident #5 saying she wanted to kill herself, when PA-B was notified. Interview on at 11:48 a.m., the said she had written the note. She said she thinks she had told the POA but did not document she had called the POA. She said the resident had spoken about wanting to kill herself and that is why they contacted PA-B because it was a significant change for Resident #5. 3. Interview on at 1:25 p.m., the said on , the Advanced Registered Nurse Practitioner (ARNP) C wrote to D/C and start 250mg PO for Resident #1. The said the ARNP-C would write in her progress notes she was contacting family and because the ARNP-C documented she was contacting the POA they though they did not have too. The medication changes were due to Resident #1 was having major changes to her behavioral so they contacted the ARNP-C who made medication changes. The said on , Resident #1 was having a hard time moving her left arm. She always had problems moving her right arm, but she was now having problems moving her left. They made home health (HH) aware of the left arm being weak but did not find documentation they had made the daughter, who is the POA aware of the request they had requested HH to evaluate for the left arm , which she said was a change in condition. The said the Resident #1 was sent to the ED for evaluation due to a change in her	A 025		

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A 025	Continued From page 4 condition on . . . . The . . said Resident #1 was leaning to her right side, unable to feed herself and unable to lift her arms . . . . . , and they informed POA. The physician had ordered them to send Resident #1 to the hospital for evaluation for the change in condition. Record review found on , Resident #1 was taken to the hospital for a decline in condition. Record review found no documentation of the behaviors which lead to the , , ARNP-C being consulted or making medication changes. Resident #1's Narrative Charting did not contain documentation of any behaviors from . . . . . through . . . . The Narrative Charting did not include any notifications to the family of behaviors, behavior changes or the need for , , consultation, from . . . . until . . . . . when the family was notified Resident #1 was being sent to the hospital. Class III	A 025		