STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964922	09/14/2016
NAME OF PROVIDER OR SUPPLIER **PACIFICA SENIOR LIVING OF PALM BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **4760 JOG ROAD** **GREENACRES, FL 33467**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced Relicensure with Extended Congregate Care (ECC) survey was conducted on 13th and 14th, 2016 at Pacifica Senior Living Of Palm Beach (License #9409). The facility had deficiencies at the time of the visit.

0010 Admissions - Continued Residency

Based on observations, interviews and record review, the facility failed to ensure the required Interdisciplinary Care Plan was developed and implemented for 1 of 2 sampled Residents (1) who was admitted to hospice services; and, failed to ensure a new health assessment (AHCA Form 1823) was completed for 1 of 2 sampled Residents (10) who had a significant change in status.

The findings included:

A) Review of Resident 1's records conducted revealed he was admitted to the facility on . He was admitted to hospice services on .

Observations of Resident 1 conducted revealed the following. On at 9:21 AM, he was observed sitting in his wheelchair at a dining . His head was drooping but he was responsive to staff interactions. On at 12:15 PM, he was observed at lunch. He rolled away from the table multiple times. He required frequent cueing from staff to stay at the table, to eat his food, and had to intervene when he pocketed a dinner roll in his mouth and refused to chew, swallow or spit out the bread.

In an interview conducted at 12:32 PM, Resident 1's Hospice Nurse stated he had been on hospice services since 2016. He requires assistance with all activities of daily living. He has had difficulty with chewing and swallowing food and receives a mechanical soft diet currently.

Review of Resident 1's records revealed the following:

1. There was no care plan developed by hospice. There was no Interdisciplinary Care Plan developed by hospice in consultation with the assisted living facility (ALF) that specified the tasks to be performed by hospice staff, and tasks to be performed by ALF staff.

2. An "Initial Integrated Plan of Care" developed by hospice staff dated included:
A. "ALF - Need for observation and assessment of altered comfort"
B. "ALF - Need for skilled teaching related to self-care ."

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C. "ALF - Instruct Caregivers on how to assist with ADL's"
D. "Caregiver will demonstrate ability to assist patient with ADL's."
E. "Instructed Caregiver how to assist with ADL's, [lace items of care/personal belongings within view/reach when possible."
There were no other identified needs or services to be provided by ALF staff identified in the care plan.

This was brought to the facility's Resident Care Director on at 11:40 AM. She stated she would look in to it. At 12:15 PM, she stated they had no interdisciplinary care plan for Resident 1. This was discussed with and acknowledged by the Administrator on at 1:45 PM.

B) Review of Resident #10's health assessment (AHCA Form 1823) dated / / had diagnoses listed, including ( ), ( ), Sclerotic (ASHD) and Mild . The assessment also documented that the resident was "independent" with ADLs (activities of daily living) including ambulation, bathing, dressing, , toileting and tranferring. It also documented that the resident required "compression stockings, medically necessary to be worn full time." During further review of Resident #10's record, it showed the start of treatment by a home health agency for a right heel pressure on / /.

On / / at 11:25 AM, Resident #10 was observed seated in a recliner with a bandaged right foot and no compression stockings on his legs. On at 9:30 AM, the Resident Care Director/LPN (licensed practical nurse) ackowledged the resident required assistance with all ADLs and that the current health assessment dated was not accurate and reflective of the resident's current status. She also confirmed that the resident was not assisted with the application of compression stockings due to the wounds on his heel at this time. During a subsequent interview on / / at 2:00 PM, she acknowledged that the resident had a (2) pressure that she was unaware of and that a new health assessment had not been completed as a result of these significant changes in the resident's status. No other health assessments were found in the resident's record.

Class III

0025 Resident Care - Supervision

Based on observation, record review and interviews, the facility failed to maintain a written record of a significant change in a resident's status and failed to notify the resident's representative of a significant change, for 1 out of 2 sampled residents (Resident #10).

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The findings included:

Review of Resident #10's health assessment (AHCA Form 1823) dated 5/25/16 had diagnoses listed, including ( ), ( ), Sclerotic (ASHD) and Mild . The assessment documented that the resident required "compression stockings, medically necessary to be worn full time."

On at 11:25 AM, Resident #10 was observed seated in a recliner with a bandaged right foot and no compression stockings on his legs. On at 9:30 AM, the Resident Care Director/RCD/LPN (licensed practical nurse) ackowledged the resident was not assisted with the application of compression stockings due to the wounds on his heel at this time. She stated he "did not have any pressure sores, and that a home health agency was treating the wounds on his right heel". At this time, documentation of the wounds was requested. At 12:30 PM, a home health agency nurse presented a document showing start of care for 2 pressure sores on the resident's right heel dated . During a subsequent interview with the RCD/LPN on at 2:00 PM, she acknowledged that the resident had (2) "pressure sores" that she was unaware of and that there was no documentation by the facility of this significant change and notification to the resident's representative.

There was no documentation of the significant change, and subsequent notification to the resident's representative by the facility, was found at this time in the resident's record. The facility was unable to prove any form of notification was provided to Resident #10's representative and/or healthcare provider regarding the (2) pressure sores on his right heel.

Class III

0054 Medication - Records

Based on observations, interviews and record review, the facility failed to ensure staff who assistance with self-administration or administration of medications to residents maintained a daily and accurate records of medications received for 2 of 4 sampled Residents (3 and 7).

The findings included:

Review of medication systems was conducted and . The following concerns were identified:

A) Review of Resident 3's medical records revealed an AHCA Form 1823 (medical

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examination) that documented pertinent diagnoses of , Parkinsonism and . She required assistance with self-administration of medications. A written Health Care Provider (HCP) order dated / called for (a controlled substance) 1 milligram (MG) by mouth 3 times a day as needed for agitation. Further review revealed the following concerns:

1. A form titled Controlled Drug Record/Individual Resident's Record related to the medication inventory documented the date and time individual pills were removed from inventory. The resident's 2016 Medication Administration Observation (MOR) record documented when individual pills were actually received by the resident. The following discrepancies were identified:
A. 1 pill removed on / at 5:00 PM was not documented on the MOR
B. 1 pill removed on at 5:00 PM was not documented on the MOR
C. 2 pills removed on at 10:00 AM and 6:00 PM were not documented on the MOR
D. 1 of the 3 pills removed on at 10:00 AM, 5:00 PM or 9:00 PM was not documented on the MOR
E. 1 of the 2 pills removed on at 10:00 AM or 5:00 PM was not documented on the MOR
F. 2 of the 3 pills removed on at 9:00 AM, 5:00 PM or 10:00 PM were not documented on the MOR
G. 2 of the 3 pills removed on / at 7:00 AM, 2:00 PM or 5:00 PM were not documented
H. Neither of the 2 pills removed on / at 8:00 AM and 4:45 PM were documented on the MOR

2. The Controlled Drug Record/Individual Resident's Record form related to the resident's current container of a 30-day supply of documented a quantity of 2 pills left as of / at 5:00 PM. Observation of the actual container conducted at 10:05 AM with the facility's Resident Care Director (RCD), a Licensed Practical Nurse, present, revealed 1 pill was left in slot 1 (photographic evidence obtained). She acknowledged the observation and stated she would look in to it. On at 1:32 PM, the RCD stated the current container actual had a pill in slot 7. At this time, this writer asked to be taken to the container for observation and was escorted by a facility nurse for the observation. Upon observation, slot 7 was observed with a pill inside, the foil had been taped shut. This writer requested the container be delivered to the Administrator and/or RCD for observation. On at 1:39 PM, photographic evidence of this container was obtained. Comparisons of the "before" and "after" photographic evidence revealed slot 7 to be open and empty "before", and closed with a pill inside "after". Please note, the initial and final observations of her entire supply revealed 3 separate, and un-used 30-day supply containers of this medication, these medications remained undisturbed. This concern was discussed with and acknowledged by the Administrator and RCD at 1:45 PM.

3. Review of Resident 3's , 2016 MOR and other medical records related to Resident 3's use revealed staff documented she received this medication 22 times in

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2016 so far. The reason for and outcome of taking this "as needed" medication was documented only 3 times out of 22 doses given. This was brought to the attention of the RCD, on 09/14/2016 at 10:10 AM. She stated facility policy is for staff to document the reason and effectiveness for all "as needed" medications on the reverse side of the MOR, and that she would look in to it. At 11:30 AM, the RCD stated she could not locate any documentation related to this concern.

B) Review of Resident 7's medical records revealed the following:

1. Her AHCA Form 1823 (medical examination) documented she required assistance with self-administration of medications.

2. An Evaluation recommended the resident take 15 MG at bedtime for .

3. A HCP order called for 15 MG at bedtime "as needed".

Review of her 2016 MOR conducted at documented she received a dose on but there was no documentation showing the reason for and the effectiveness of the "as needed" medication. This was brought to the attention of the RCD, on at 12:08 PM. She had previously stated facility policy is for staff to document the reason and effectiveness for all "as needed" medications on the reverse side of the MOR, and that she would look in to it. At 12:15 M, the RCD stated she could not locate any documentation related to this concern.

The above concerns described in items I and II above were discussed with the Administrator and RCD on / at 2:13 PM. They had no additional information or documentation to provide at that time.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observations and interviews, the facility failed to ensure facility appurtenances were maintained in good working order, for 1 of 7 sampled Cottages (5) by allowing flooring in disrepair. This had the potential to affect all 13 current residents of this cottage.

The findings included:

On at 11:15 AM, during observations of Cottage 5 physical plant, the following observation was made (photographic evidence obtained). The laminate flooring in the area surrounded by the

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kitchen, dining area, living room, and the hallway to the building entrance had several deep gouges, some extending down the hallway about 20 feet. Portions of the laminate flooring had broken off, some of the edges of the laminate were deteriorating and curling up. This was brought to the attention of the Resident Care Director on at 12:40 PM. This was discussed with and acknowledged by the Administrator on at 1:45 PM.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Pacifica Senior Living Of Palm Beach
4760 Jog Road
Greenacres, FL 33467

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at 561-381-5840.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD/jw

XG90

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