STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965265	**12/13/2017**
NAME OF PROVIDER OR SUPPLIER **PACIFICA SENIOR LIVING OF BELLEAIR**	STREET ADDRESS, CITY, STATE, ZIP CODE **620 BELLEAIR ROAD** **CLEARWATER, FL 33756**	

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

0000 - Initial Comments

Assisted Living Facility

Two complaint investigations, (CCR# 2017014526 and CCR# 2017010730), were conducted at Pacifica Senior Living of Belleair, Assisted Living Facility, on . Pacifica Senior Living of Belleair, Assisted Living Facility, had deficiencies at the time of the visit.

(License # 9666)

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interviews, the facility failed to provide services and oversight for 1(Resident #2) of 3 residents sampled for .

Findings included:

The maintenance director stated on at 9:45 am that the facility has several generators and they were working during the recent hurricen but one of them for Cottage #6 had a problem with the cooling sensor which made the generator a lot of oil. The maintenance director further stated he called the generator company and they ordered a new sensor. Meanwhile to keep the generator going, the generator was stopped when the oil was low and it was topped off. On the night of , the generator was stopped at 9:45 pm and refilled with oil. Per the maintenance director, the power was off in the facility for about 30 minutes. The maintenance director stated all of the staff had flashlights and lanterns to use when the power went out.

Direct Care Staff B stated on at 1:35 pm that she opened the doors to residents' when the power went off during the hurricane so the emergency power for the exit signs would help to illuminate some of the residents' . Staff B said she only had one flashlight for herself and no other light source was available for residents. She stated most of the residents slept during the night but Resident #2 would get up during the night so she always had her light on in the . Staff B stated she was the one that heard Resident #2 around 10:00 pm and went to her found Resident #2 on the floor. Resident #2 was complaining of pain on the right side of her hip so 911 was called and she was sent to the hospital for evaluation. The power came on again in the building around the time the

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paramedics arrived, after Resident #2 had .

Staff B stated she knew Resident #2 always had a light on in her when she got up at night, she could get to the falling. Per Staff B, Resident #2 was very careful and she had never before this time. Staff B said there was no light in her the power was shut off so she because she couldn't see where she was going. Staff B stated that all she had was one flashlight and Staff B needed that one so she could keep track of the other residents. Staff B said "There should have been extra lights for us to put in the of the residents who got up in the night especially those who were used to having a light on."

Direct Care Staff C stated on at 1:50 pm he was working at Cottage #6 on and he stated the maintenance man told him he would be shutting down the generator at 9:45 pm so Staff C went and got his flashlight and started checking on the residents in Cottage #6. The exit lights were on so he and Staff B opened up the doors to the residents' so they would have a little light in their . Staff B called to him and said Resident #2 had and to call 911. He stated he noticed there was no light in Resident #2's . Staff C said Resident #2 always has a light on in her because the power was off, there was no light for her to see where she was going. Per Staff C, "We were only given two flashlights and no lanterns so we didn't have a lot of light when the generator was stopped."

Record review of the incident reports on revealed Resident #2 did on and was sent out to the hospital for evaluation. The family and the doctor for Resident #2 were notified.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on interviews and record review, the facility failed to maintain an up-to-date admission/discharge log listing names of all residents and each resident's date of admissions, place admitted from, date of discharge, reason for discharge, and the place discharge to for 1 (Resident #2) of 6 residents sampled for the admission and discharge log.

Findings included:

A record review conducted on revealed that Resident #2 was not listed in the

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admission/discharge log even though she was admitted to the facility in , 2017 and discharged in , , 2017.

An interview conducted on at 1:00 pm, the Administrator acknowledged and confirmed that the admission and discharge log was not up-to-date because it was missing the date of admission, place admitted from, date of discharge, reason for discharge, and the place discharge to for Resident #2.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on interviews and record review, the facility failed to get approval from emergency management for the facility's emergency plan.

Findings included:

A review of the emergency management plan on at 2:00 pm revealed a certificate from the local emergency management agency, which stated the certificate is valid through , , 2016.

The administrator stated on at 2:00 pm that their emergency management plan had not been approved for 2017 because the plan had not been sent in for approval since 2015. The plan was now being revised and it will sent to the emergency management unit as soon as it is completed.

Class III