STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964922	12/20/2017
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 licensure complaint survey, CCR# 2017009869 was conducted on at Pacifica Senior Living of Palm Beach, License #9409, and the investigation was completed on . Two of the 4 allegations were substantiated. The facility had deficiencies at the time of the investigation.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on resident record review and staff interview, the facility failed to ensure 1 of 3 sampled residents (#1) was examined by a health care provider within 60 days of admission to the facility, and that a signed and completed medical examination report (AHCA Form 1823) was submitted to the administrator of the facility to assist in the determination of the appropriateness of the resident's admission and continued stay in the facility. This report is to become a permanent part of the resident's record at the facility and made available to the Agency during inspection and upon request.

The findings included:

A review of Resident #1's medical record revealed Resident #1 was originally admitted for respite care from - . Documentation completed for admission on was a skin assessment and a facility initiated assessment of Resident #1's level of assistance required for Activities of Daily Living (ADLs). A Care Plan was initiated by the facility at this time ( ).
There was no AHCA Form 1823 (Medical Examination Report) completed within 60 days prior to admission on found within the resident's medical record.

From - , Resident #1 was again admitted to the facility for a week of respite care. At this time, another skin assessment was completed at the time of admission, but no further ADL assessment was done. The Care Plan initiated on was still in effect.
There was no AHCA Form 1823 (Medical Examination Report) completed within 60 days prior to admission on found within the resident's medical record.

During interview with the Resident Care Director and Community Relations Director on at 3:30 PM, they confirmed the entire record for Resident #1 was provided for review. No further documentation was provided.

Class III

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

Based on resident record review and interviews, the facility failed to notify the 1 of 3 resident's health

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care provider and the resident's family member/power of attorney regarding a significant change (Resident #1).

The findings included:

On , a skin assessment was completed for Resident #1. It was noted in the Charting Notes on this date: "Did skin assessment with Cottage Manager, Resident showed area to right back, lower middle back, and left . Unable to say how occurred."
There was no documentation found that staff notified Resident Care Director, Administrator, Resident's family, or Resident's health care provider regarding the change in Resident #1's condition.

On at 1:00 PM, Resident #1's daughter, who is also her Power of Attorney, stated she was never notified by staff of the areas on her mother. She was not aware until she observed some of these areas during lunch with her mother on , after her mother was discharged from the facility.

During interview with the Resident Care Director on at 3:30 PM, she confirmed that the family and physician should have been notified of the change noted during the resident's skin assessment on .

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on resident record review, review of the facility's policy and procedures, and staff interviews, the facility failed to follow its policy and procedures related to reporting suspected resident for 1 of 3 residents (#1).

The findings included:

Resident #1 had been admitted to the facility for 7 days of respite care. During interview with Resident #1's daughter on at 1:00 PM, she stated she had noticed on her mother's hand and right and left upper arms when she was having lunch with her on the day she picked her mother up from the assisted living facility. After further inspection, she also noted several additional areas on her upper and lower back. The daughter added, "I do not have any concerns that staff were to my mother, but I do think my mother's may have been aggressive with her." The daughter explained that when she came to the facility to collect her mother's things, her mother's thought she was there trying to steal the 's belongings. The became aggressive

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with her [the daughter]. When staff finally arrived in the , they were able to redirect the . The daughter stated she had not witnessed the being aggressive with her mother.

Resident #1's daughter stated, "After I saw the on my mother, I called the nurse on duty. The nurse said she asked the staff if my mom may have out of bed. I told her that I thought my mother's might have pushed her against the wall or been aggressive to her. Nothing was ever really done about it. I never got any answers...I did take my mother to the hospital to be checked out. There was no broken bones, just the ."

A review of confidential information/records, revealed Resident #1 had numerous ecchomotic areas on the resident's upper and lower back, and upper right and left arms.
A review of the list of medications prescribed and provided to Resident #1 did not show use of , or .

The Skin Assessment conducted at the time of admission on does not document any / areas on the resident's skin at this time, only redness on lower legs.

Charting Notes for at 2:30 PM documents, "Did Skin Assessment with Cottage Manager, Resident showed ecchyotic areas to right back, lower middle back and left ; unable to say how occurred."

During an interview with the Resident Care Director (RCD) and Community Relations Director (CRD) on at 3:30 PM, the RCD stated, "The Procedure for any unexplained is to report to the nurse in charge. The nurse will fill out an incident report, notify family, and call the doctor; if we suspect a , we would send to the hospital. Any allegation of suspected should also be reported to the nurse in charge who would fill out an incident report and contact the proper authorities."

A review of the facility's policy on documents: "...when is suspected, staff and volunteers are required to immediately notify the Resident Care Director"
It is also documented in the Procedure that when a staff member is told by a resident [including resident's family] of an incident which appears to be any form of or neglect, the incident is immediately reported to the Resident Care Director or Executive Director (Item #3).
Upon notice of reported [suspected] , the resident is to be interviewed and responses documented; A medical evaluation of the resident is arranged, as necessary; The family is notified immediately of the incident; The physician is notified immediately, as necessary (Item #4).
Reporting of any suspected, alleged, or witnessed will be completed according to state reporting requirements (Item #5);

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An investigation will take place surrounding the cause of the (Item #6). [GP 11 -Elder , Revised /1]

On at 3:30 PM, Per interview with the CRD and RCD, they confirmed the facility policy and procedure requirements were not followed.

Class III