STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964870	**12/27/2018**
NAME OF PROVIDER OR SUPPLIER **PACIFICA SENIOR LIVING FORT MYERS**	STREET ADDRESS, CITY, STATE, ZIP CODE **9461 HEALTHPARK CIRCLE FORT MYERS, FL 33908**	

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

0000 - Initial Comments

An unannounced off hours complaint survey for CCR# 2018018041, CCR# 2018015392 and CCR# 2018015289 was conducted on at Pacifica Senior Living, an assisted living facility (license #9346) in Fort Myers, Florida.

Complaint CCR# 2018018041 contained 2 allegations of which 1 was substantiated with citation & the other was unsubstantiated.

Complaint CCR# 2018015392 contained 5 allegations of which all 5 were unsubstantiated.

Complaint CCR# 2018015289 contained 3 allegations of which 2 were substantiated with citation & 1 was unsubstantiated.

The following is description of the deficiencies.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review, and staff interview, the facility failed to determine the continued appropriateness of 1 (Resident #11) of 3 residents reviewed for appropriate care and services as it relates to change in condition, loss and development and worsening ,

The findings included:

According to the National Advisory Panel a , is full-thickness loss of skin, in which adipose (fat) is visible in the and tissue and epibole (rolled edges) are often present. and/or eschar may be visible. The depth of tissue damage varies by anatomical location. Undermining and may occur. Fascia, , , ligament, cartilage and/or bone are not exposed. If or eschar obscures the extent of tissue loss this is an pressure injury.

On at 6:40 a.m., interview with Executive Director (ED) she said there is 1 resident with , in the facility at this time and she said he was almost healed up

On at 11:00 a.m., observed care change on Resident #11's left , by home health nurse who does the change daily. After removing the old , which had moderate amount of yellow drainage, the nurse proceeded to clean area with normal . The opening

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was approximately the size of a quarter and approximately ½ inch deep revealing exposed and yellow at the bottom. While cleaning, the nurse placed some wet gauze and Q-tip inside the . The entire gauze and total tip of the Q-tip went into the . It appeared that the was even wider inside than the opening on the surface. Executive Director of facility was present at care observation and is also a nurse (LPN). appeared to be a or because of the in the bottom and the visible .

On at 11:10 a.m., Home Health Nurse (LPN) said that last week the was covered over with and then showed a picture of the area on her cell phone. She said that she takes pictures of the weekly for the doctor. She said that over the weekend the nurse said that it seemed to explode; drainage was all over, now it looks the way it does. The nurse was unaware the facility could not care for resident with or 4 .

On at 11:15 a.m., ED said she was unaware the had gotten that bad. She said, "I had no idea."

Resident #11's health assessment dated recorded the resident has the following diagnosis: , deficiency and .

Record review of Advanced Registered Nurse Practitioner (ARNP) visit notes for Resident #11 showed on - Appetite poor-not eating, complaint of right , no documented skin issues. Current . On , ARNP records that resident continues to decline; she is only eating about 30% of her meals, lost in last week. General skin exam skin is warm and dry, no rashes, or . On , ARNP writes resident had 2 since last week, hospital visit on for . General skin exam open left , 4"x 3" staff to monitor and encourage increase fluid intake, prevention, preventions and .

On ARNP notes, Resident #11 now has a , on her left . ARNP writes with tissue left , - 3"x 2" dry, no drainage, and redness around edges. Also now complaining of right , .

On ARNP records , on left , a with tissue; size 3"x 2" & resident now has right /heel . Consult with care , - will stop (debrider) start wet to dry for 3 days then re-start . Treatment done by home health nurse. Once a day changes. .

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On - Re-eval of on left , and re-eval of open on right . Daily updates and report from home health nurse have been provided to the provider. ARNP also wrrote, that staff need to be reminded by nurse each visit to remind resident to stay off/or not to lay on her left side when she is sleeping.

from MOR records that resident's dropped from to on .

Record review of home health skilled nursing notes for care of left , and right heel , from to noted some of the following: On nurse wrote, resident of and cloths saturated. Has a slipper on her left and nothing on her right that is being treated for . Unable to locate any dry pants or depends. Staff member went to laundry room and could not locate the five pairs of hospital socks we brought in for the resident. Gave me a pair of blue stretch pants. Treatment done as ordered. Callus on right starting to off. Then on nurse wrote: found resident in bed laying toward her left lateral side. Drainage noted on sheet. Left soiled. Unable to assess left bed due to yellow tissue entire bed.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation, review of policies and procedures and staff interview, staff failed to maintain dignity and privacy and failed to follow control practices during care in 1 (cottage #5) of 5 cottages observed.

The findings included:

Review of the facility's policy and procedure for standard precautions/ control dated , revealed personal care assistants with occupational exposure to or other will follow standard precautions and wear personal protective equipment when coming into contact with all , , , (except sweat), non intact skin, and .
Standard precautions include the appropriate methods for: hygiene, personal protective equipment, injection safety, environmental cleaning, use of disposable and reusable equipment and , hygiene/ etiquette.

On at 6:00 a.m., Resident Care Assistant Staff A was observed providing morning care,

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including , to Resident #5. The door to the hallway was left opened and loud music was coming from the staff's pocket. She said she used her personal phone to play her own music while providing care as it made time go faster. The resident's roommate was observed sleeping while the loud music was playing. The resident care assistant acknowledged she was disturbing the resident's sleep with her loud music.
Staff A combed Resident #5's hair with the same gloves she changed the briefs. With the soiled gloves still on, she took the resident to the dining area.
She removed the gloves and took a bag of soiled briefs into Resident #7's room. She placed the bag on the resident's chair. Staff A donned 2 pairs of gloves and changed Resident #7's briefs. With the gloves still on, she left the room and went to the kitchen to make a phone call. She returned to the room and removed one pair of gloves. She then changed Resident #8's briefs and made the bed with the soiled gloves on. She took the resident to the common area. She removed the gloves and walked to Resident #8's room where she picked up soiled briefs with her bare and placed into the bag of soiled briefs. Staff A took the bag to Resident #4's room and placed it on the floor next to the bed. She donned a pair of gloves and took the resident to the bathroom to change her briefs without washing or sanitizing her .
Staff A changed her gloves and changed Resident #3's brief who was of . With the soiled gloves still on, she went to the clean utility closet to retrieve clean briefs.
Staff A removed her gloves and proceeded to Resident #11's room. She donned a pair of gloves without washing or sanitizing her and proceeded to check the resident's briefs.

On at 7:00 a.m., Staff A acknowledged the breach of control and said she received training on washing and universal precautions.

On at 8:00 a.m., the observation was shared with the administrator.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, record review and interview, the facility failed to ensure 2 (Resident #2 and #3) of 3 sampled residents received appropriate assistance with self administration of medication to ensure the residents received medications according to the physician's orders.

The findings included:

1. Review of the clinical record for Resident #2 revealed on the physician issued an order for

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250 milligrams, tablet every 8 hours for seven days for a consistent with .
The medication was scheduled to be taken at 8:00 a.m.; 4:00 p.m. and 12:00 a.m. from to .

The medication observation record (MOR) for failed to reveal documentation the resident received the 12:00 a.m. dose from to .

The MOR contained documentation the medication was administered beyond the 7 days at 8:00 a.m. from through .

There was also documentation Resident #2 received the 4:00 p.m. dose beyond the 7 prescribed 7 days on and .

Observation on at 8:13 a.m. of the card revealed one tablet of remaining to be administered.

On at 8:15 a.m., Medication Technician Staff B confirmed Resident #2 did not receive the medication in accordance to the physician's orders. She said she could not understand why the medication was scheduled for 12:00 a.m. since there is not always a medication technician available at night. She said she kept administering the medication beyond the 7 days ordered since there were pills remaining in the card.

On at 8:45 a.m., the administrator said the med tech supervisors are supposed to check the MORs at night to make sure they assist with medications scheduled at night. After looking at the MOR for Resident #2 she said "you're absolutely right the medication was not administered as it should have".

2. Review of the MOR for Resident #3 revealed the medications listed included , 400 milligrams one tablet by twice daily. On and there is documentation Resident #3 received the medication at 9:00 a.m.
Complete review of the clinical record failed to reveal a physician's order for the .
On at 4:00 p.m., the administrator said she could not locate an order for the , . She called the pharmacy and they never received that order.

Further review of the MOR for Resident #3 revealed an order for 9.5 milligrams patch to be applied to the skin daily. Documentation on the MOR revealed the patch was not applied from through . Each day the medication technician documented in the of the MOR the medication was on order.

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On [redacted] Med Tech Staff B said she heard the family wanted to have the patch discontinued. She said she guessed they must have changed their mind and they re-ordered it.

On [redacted] at 11:57 a.m., the administrator said she just spoke to the pharmacy. The facility did not reorder the medication until [redacted]. She said there was no documentation the physician was notified the resident did not receive the medication as ordered.

Class III