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
	AL11964922	A. BUILDING: _____ B. WING _____	06/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING OF PALM BEACH	4760 JOG ROAD GREENACRES, FL 33467

(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 licensure complaint survey, Complaint Number 2019003960, 2019004627, 2019005643, 2019005968 and 2019006499, was conducted on [redacted] at Pacifica Senior Living of Palm Beach. The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents 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 58A-5.020, 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	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 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 observation, review and interview, it was determined the facility failed to maintain a written record of any signficant changes and/or illnessess that resulted in medical attention, for 5 out of 8 residents ((Resident #1, #2, #9, #10 and #11). As evidence of the facility failure to document residents that were exposed to . . . . . and required treatment. Findings Include: On through a Complaint Survey was conducted at the facility. On . between 2:40 PM and 3:08 PM, this surveyor reviewed Resident #2 facility file. A review of the "Narrative Charting" in file did not reveal any mention of . . . . . However, review of Resident #2's MOR for - in file documents . . . . . 0.1 % cream apply to . . twice daily until resolved. MOR . . . . . - . . . . . documents . . . . . 0.1 % cream apply to	A 025		

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A 025	Continued From page 2 twice daily until resolved. During a confidential interview on at 12:19 PM, it was revealed that they moved their family member (resident) from the facility the end of to (another facility). It was revealed the resident had , confirmed by a medical professional working at the facility. During interview with Resident #9 on at 10:52 AM, resident stated he/she had been bitten and showed surveyor healed sores. "They took my clothes." The Resident stated, a family member brought (him/her) something. Also said "the doctor came and put some plaster on me for weeks." During interview with Resident #10 on at 11:07 AM, resident stated he/she had been bitten and showed this surveyor healed . Resident stated he/she "Put cream on it. But that's over." During interview with Resident #11 on at 11:19 AM, resident stated he/she had some bugs a few times (pointed at healed sores) and stated: "They put some stuff on it." During confidential interview #2 on at between 11:27 AM and 11:35 AM, the following was revealed. "I had one patient who had that I the provide care for." In addition, the individual stated: "I had another patient who had as well. This was a few months ." between 3:10 PM and 3:49 PM, this surveyor reviewed Resident #1 facility file and observed a (Care provider) dated for cream 0.1 % ,	A 025		

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A 025	Continued From page 3 60g. Apply . . until symptoms resolved. - (Doctor), MD, HMDC. Also observed (Care provider) Physicians' telephone Order dated for 0.5 cream; apply sparingly to scattered . . . on abdomen and upper twice daily until resolved." This surveyor also observed Resident #1 MOR - documenting . . . . . 0.5 cream: Apply to affected areas (on Abdomen and upper . . .) twice daily until resolved. Documentation shows application shift and shift applying such. This surveyor also reviewed resident #1 "Narrative Charting" in file. No documentation of . . or treatment observed. . . . . . at 9:26 AM, this surveyor interviewed the Director of Nursing (DON) who stated, "There was never confirmed by doctor that they had , they were given medication." To his knowledge, there was no one else that had or was treated for during that time. The DON also stated that they had "not done a scraping test" and that they were prescribed medication for the . . by doctor. This surveyor shared with the DON that during interview with residents of cottage 7, three (3) of six (6) residents interviewed stated they had experienced rashes during the same period as Residents #1 and #2. However, there was nothing observed on the Incident report (or within the file) related to Resident 9, 10 and 11 having a , or contact with family or responsible person(s) reporting such by this surveyor. On , this surveyor spoke with DON and Business Manager, this surveyor requested documentation for any treatment conducted in the	A 025		

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A 025	Continued From page 4 cottage for possible . . . . . Nothing was provided during the time of the onsite survey. On at 4:31 PM, this surveyor met with the Business Manager and Director of Nursing to conduct the Exit Interview. The surveyor findings were discussed, no additional information was provided. Class III	A 025		
A 032 SS=D	58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(i) Resident Care - Elopement Standards 58A-5.0182 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 58A-5.0181(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 58A-5.0191(10)(a) or (c),	A 032		

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A 032	Continued From page 5 F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. 429.41(1)(a)3 & 3(l),FS 3. Resident elopement requirements.-Facilities are required to conduct a minimum of two	A 032		

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A 032	Continued From page 6	A 032		

resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.
(I) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills.

This Statute or Rule is not met as evidenced by:
Based on observation, review and interview, the facility failed to ensure that proper/or adequate staff attention was directed toward residents at high risk for elopement, with special attention given to those with 's or related assessed at high risk, for 1 out of 5 sampled resident (Resident #6).

Findings Include:

a) Review of confidential records revealed Resident #6 eloped from the facility on , at approximately 0600. Resident #6 was located at 0620 by the local police mile from the facility at a pharmacy; facility at this time notified. Resident returned by police to the facility at 0630.

On , an unannounced Complaint Survey was conducted at the facility. During the survey between 12:51 PM and 1:30 PM, this surveyor reviewed Resident #6's file, including the "Narrative Charting" documents, and did not observe an entry for the incident. There was also

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A 032	Continued From page 7 no report from the local County law enforcement agency who returned the resident to the facility. During review of Resident#6's file on , this surveyor reviewed the Health Assessment (AHCA form 1823) dated and observed the "Elopement Risk" box was checked YES. In addition to stating resident was an elopement risk, it also stated Resident #6 had short term memory loss, and sundowning with agitation and intermittently. However, the facility failed to ensure that staff's attention was directed toward residents at high risk for elopement, with special attention given to those with or related assessed at high risk. at 11:27 AM, this surveyor met with the Director of Nursing (DON) who provided this surveyor with an updated 1823 for resident #6. The DON stated: "You said you needed the updated 1823, the one from yesterday was wrong." This surveyor advised that an updated 1823 was not requested, as the one from previous day was reviewed, to which the DON stated: "Oh' I thought you said you needed it, it's updated." On at 4:31 PM, this surveyor met with the Business Manager and Director of Nursing to conduct the Exit Interview. This surveyor informed them of the findings; no additional information was provided. Class III	A 032		