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
	AL11965265	A. BUILDING: _____ B. WING _____	07/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING OF BELLEAIR	620 BELLEAIR ROAD CLEARWATER, FL 33756

(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 A complaint investigation (Complaint Number: 2019010847) was conducted at Pacifica Senior Living of Belleair Assisted Living Facility on . . . . . Deficiencies were identified at the time of survey.	A 000		
A 056 SS=J	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , . . . , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff	A 056		

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A 056	Continued From page 1 who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing	A 056		

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A 056	Continued From page 2 the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that prescriptions for residents who received assistance with self-administration were filled or refilled in a timely manner for six (#1, # #3, #5, #6, and #7) of 72 sampled residents, including Resident #1 who missed doses of a , and medication, was found unresponsive, and subsequently . Missed medications included, but, were not limited to those for the treatment of high , , , prevention, high , , , , and . Findings Included: 1. On record review revealed Resident #1 was diagnosed with , , { }, II, high , , , fatigue, , frequent and difficulty walking. On , a review of medication observation records (MORs) for and for Resident #1 revealed the following medications were not provided as ordered	A 056		

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A 056	Continued From page 3 (photographic evidence obtained): a. , 81 mg take 1 time daily, not provided on and from to . b. 40 mg (treat high) take 1 time daily, not provided on and from to . c. 3.125 mg (treat high , and) take 1 time daily, not provided on and from to 06-30-19 and to 07- . d. , 20 mg (treat ,) take 1 time daily, not provided from to -19 and to . e. , 5 mg (treat) take 1 time daily, not provided on and from -19 to and to . f. 325 mg take 1 time daily, not provided on and from to 06-30-19 g. , 10 mg (Medication) take 1 time daily, not provided on and from to . h. 100 mg (treat high ,) take 1 time daily, not provided on , 06- and from to . i. 500 MG (Medication) take 1 time daily, not provided on 06- and from to . j. , 40 mg take 2 times daily, not provided on and from to 06-30-19 k. (treat enlarged ,) 0.4 mg take 1 time daily, not provided on , and from to 06-30-19. l. D3 1,000 MCG take 1 time daily, not provided on and from to 06-30-19 m. 7.5mg (treat enlarged ,)	A 056		

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A 056	Continued From page 4 take once daily, not provided from . . . . . to n. . . . . 5% (treat . . . . .) patch apply to lower every 12 hours, not provided from . . . . . to . . . . . and . . . . . to 07- . A record review conducted on revealed emergency medical services (. . .) was called on at 6:45 AM due to Resident #1 being found unresponsive in his bed. Staff initiated and the resident was transported to the local hospital emergency room (ER) via . . . A record review conducted on revealed the facility was notified by the hospital on . . . at 10:00 AM that Resident #1 had . Record review of the hospital's emergency room records conducted on . . . . revealed . . performed for 30 minutes prior to transporting Resident #1 to the ER. Resident #1 arrived at the hospital on in . . . with a . . . /diastolic . . . . of zero. Review of the hospital's expiration record report conducted on . . . . revealed Resident #1's preliminary cause of was and his time of . . . was 07:16AM on . . . . . . In an interview with the Resident Care Director (RCD) conducted on at 12:00 PM, the RCD stated she was aware that there had been issues with getting resident medications on time from the pharmacy. The RCD stated she had not been made aware that Resident #1 was out of so many medications for the months of and . .	A 056		

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A 056	Continued From page 5 In an interview with the RCD conducted on at 5:45 PM, she stated the pharmacy, physician and family were notified that Resident #1 had not been receiving his medications. The RCD also stated there was no documentation in Resident 1's chart regarding the notification of parties. During a phone interview conducted on at 11:55 AM with the Advanced Registered Nurse Practitioner (ARNP) that worked with Resident #1's Primary Care Physician (PCP), she stated that neither her or Resident #1's PCP had been notified that Resident #1 had not received his medications as ordered in or . On at 11:20AM a follow-up phone interview was conducted with the ARNP. The ARNP stated Resident #1 could have suffered a , , or even without receiving his medications. During a phone interview with a family member of Resident #1 conducted on at 12:22PM, he stated he was not notified by the facility that his family member was not receiving their medications in or . 2. On , a review of , MORs for Resident #3 revealed the following medications were not provided (photographic evidence obtained): a. , 5 mg (treat high ,) take 2 times daily, not provided from to . b. 3.125 (treat high ,) mg take 2 times daily, not provided from to .	A 056		

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A 056	Continued From page 6 c. Saccharomyces Boulardii take 1 capsule 2 times daily, not provide from to . During a phone interview with a family member of Resident #3 conducted on at 10:15AM, he stated he was not notified by the facility that his family member was not receiving their medications in . 3. On , a review of MORs for Resident #6 revealed the following medications were not provided (photographic evidence obtained): a. , 0.25 m (treat ,) take 2 times daily, not provided from to . b. , 2.5 mg (treat high ,) take 1 time daily, not provide from to . During a phone interview with the Guardian of Resident #6 conducted on at 10:24AM, she stated that the facility did not notify her that Resident #6 was not receiving their medications in . 4. On , a review of MORs for Resident #7 revealed the following medications were not provided (photographic evidence obtained): a. 75 mg (lower risk of recurring /) take 1 time daily, not provided from to . b. , Tart 50 mg (treat high ,) take every 12 hours, not provided on to .	A 056		

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A 056	Continued From page 7 5. On . . . . . , a review of . . . . . MORs for Resident #2 revealed the following medications were not provided (photographic evidence obtained): a. , 5 mg (treat ,) take 1 time daily, not provided from . . . . . to . . . - 2019. b. . . . . HBR 4mg (treat . . . . .) take 1 tab twice daily, not provided to . . . . . - During a phone interview with the ARNP on . . . . . beginning at 11:20AM, the ARNP stated neither she nor the PCP, were informed by the facility that Residents #2, #3, #6, and #7 were not receiving their medications in or , . . . The ARNP stated that if the residents did not receive their medications, they could suffer from a . . . , ... or . . . . . . During a phone interview with a family member conducted on . . . . . at 3:02PM, she stated that she was not notified that her family member was not receiving their medication in . . . of 2019. 6. On . . . . . , a review of , . . . MORs for Resident #5 revealed the following medications were not provided (photographic evidence obtained): a. , 0.5 mg (treat ,) take 2 times daily, not provided from . . . . to . . . . . b. . . . . 40 mg (treat high) take 1 time daily, not provided from . . . . to c. , ... 10 mg (treat . . . ,) take 3 times daily, not provided from . . . to	A 056		

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A 056	Continued From page 8 d. , 10 mg (treat ,) take ½ tab daily, not provided from to . During a phone interview conducted on at 11:21 AM with the primary care physician (PCP) for Resident #5, he stated that he had not been notified that Resident #5 had not received her medications in . 7. In an interview with Staff A, a med tech and caregiver, conducted on at 11:27 AM, Staff A stated that the residents do run out of medication and sometimes they are out of medications for weeks. In an interview with Staff B, a med tech and caregiver, conducted on at 4:17 PM, Staff B stated that the residents do run out of medications. During an interview with Staff C, a med tech and caregiver, conducted on , Staff C stated the residents do run out of medications. 8. A review of the facility's policy and procedure, titled Med 07-Medication Refills with a revision date of , revealed the following: Policy: Medication refills will be obtained in a timely manner to ensure residents have all physician ordered medication available. Procedure: 3. Medications are never allowed to run out unless directed to by the physician. 5. When there is any delay in the receipt of the	A 056		

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A 056	Continued From page 9 medication that results in the unavailability of the medication to be given, the Resident Care Director is notified. During the exit interview conducted on . . . . . at 12:55 PM the RCD stated she was aware that Residents #1, #2, #3, #5, #6, and #7's medications were not filled in a timely manner and the residents did not receive their medications as ordered. Class I	A 056		
A 077 SS=J	429.176 FS; 429.52( ),58A-5.019(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52( ), FS (4) A new facility administrator must complete the required training and education, including the competency test, within 90 days after date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19.	A 077		

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A 077	Continued From page 10 (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 58A-5.019 Staffing Standards. (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to Sections 408.809 and 429.174, F.S.; and 4. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C., no later than 90 days after becoming employed as a facility administrator. Individuals who have successfully completed these requirements before , are not required to take either the 40 hour core training or test unless specified elsewhere in this rule. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule. 5. Satisfy the continuing education requirements pursuant to Rule 58A-5.0191, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect	A 077		

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A 077	Continued From page 11 on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraphs (1)(a)4. of this rule to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C.; and 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements of an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager	A 077		

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A 077	Continued From page 12 of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not [illegible] serve as an administrator of any other facility. (e) Pursuant to Section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, [illegible], which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04002. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an Administrator or designated staff who was actively involved in providing supervision and oversight necessary for ensuring medications were received timely and as ordered for six (#1, # #3, #5, #6, and #7) of 72 sampled. Missed medications included, but, were not limited to those for the treatment of high [illegible], prevention, high [illegible], and [illegible]. (Cross reference A0056) Findings Included: 1. On [illegible], a review of medication observation records (MORs) for [illegible] and [illegible] for Resident #1 revealed Resident #1 was not provided with 14 out of 15 medications as ordered by a physician from [illegible] to [illegible].	A 077		

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A 077	Continued From page 13 A record review conducted on revealed emergency medical services ( ) was called on at 6:45 AM due to Resident #1 being found unresponsive in his bed. Resident was transported to the local hospital emergency room (ER). Further record reviewed revealed the facility was notified by the hospital on at 10:00 AM that Resident #1 had Record review of the hospital's emergency room records conducted on revealed performed for 30 minutes prior to transporting Resident #1 to the ER. Resident #1 arrived at the hospital on in with a /diastolic of zero. The hospital's expiration record report was reviewed on and revealed Resident #1's preliminary cause of was and his time of was 07:16AM on In an interview with the Resident Care Director (RCD) conducted on at 12:00 PM, the RCD stated she was aware that there had been issues with getting resident medications on time from the pharmacy. The RCD stated she had not been made aware that Resident #1 was out of so many medications for the months of and . 2. On , a review of MORs for Resident #3 revealed the resident was not provided with 2 of their medications that was prescribed to treat high from to . 3. On , a review of MORs for Resident #6 revealed the resident was not provided with medications ordered to treat	A 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING OF BELLEAIR	620 BELLEAIR ROAD CLEARWATER, FL 33756

(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 077	Continued From page 14 and high . . . . , ... from . . . to . . 4. On , a review of , MORs for Resident #7 revealed the resident was not provided with medications ordered to treat high . . . . , ... and to lower risk of recurring / from . . to . 5. On , a review of MORs for Resident #2 revealed the resident was not provided with medications ordered to treat . . , ... and . . . . . from . . . . . to 6-26-2019. 6. A review of the facility's policy and procedure titled Med 07-Medication Refills with a revision date of revealed the following: Policy: Medication refills will be obtained in a timely manner to ensure residents have all physician ordered medication available. Procedure: 3. Medications are never allowed to run out unless directed to by the physician. 5. When there is any delay in the receipt of the medication that results in the unavailability of the medication to be given, the Resident Care Director is notified. In an interview with the RCD conducted on . . . . . at 5:45 PM, she stated the pharmacy, physician and family were notified that Resident #1 had not been receiving his medications; however, there was no documentation in Resident 1's chart regarding the notification of parties. During phone interviews conducted from	A 077		

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A 077	Continued From page 15 . . . . to . . . . with the residents' primary care physicians, ARNP and residents' family members it was revealed that they were not notified that residents were not receiving their medications as ordered. During the exit interview conducted on . . . . . at 6:00 PM, the lack of obtaining medications for Residents #1, #3, #5, #6 and #7 in a timely manner and the facility's responsibility was discussed with the RCD. The RCD stated that a timely manner would be to receive the medications from the pharmacy within 24 hours of being ordered or reordered. A text from the administrator at this time stated that the facility's responsibility in this situation is to communicate with the physician and the family. During the exit interview conducted on . . . . . at 12:55 PM the RCD stated she was aware that Residents #1, #2, #3, #5, #6, and #7's medications were not filled in a timely manner and the residents did not receive their medications as ordered. Class I	A 077		