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
	AL11964742	A. BUILDING: _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING OCALA	11311 SW 95TH CIRCLE OCALA, FL 34481

(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 re-licensure survey with Emergency Power Plan and Limited Nursing Services monitoring, in conjunction with a complaint investigation (complaint numbers 2022006047 and 2022006533), was conducted at Pacifica Senior Living Ocala on [redacted] through [redacted]. Deficiencies were identified at the time of the survey. The allegations for complaint #2022006047 were not substantiated. One allegation for complaint #2022006533 was substantiated.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [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] or [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 must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and	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 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 59A-36.012, 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 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, interview, and record review, the facility failed to have enough qualified staff to provide resident supervision, and to provide or arrange for resident services for 2 of 10 memory care residents observed, in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards, Resident #15 and	A 025		

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A 025	Continued From page 2 Resident #17. Findings include: During an interview on at 10:10 AM, a Hospice Registered Nurse stated she had concerns about Resident #15's care in the memory care unit since no one oversees the unit and tends to the resident. The Hospice Registered Nurse stated the staff do not get the help they need and get overwhelmed and leave. During an observation on at 10:23 AM, the Hospice Registered Nurse removed Resident #15's blankets, and the resident's brief was saturated with . The blankets and bed linens were saturated as well. During an interview on at 10:23 AM, Staff B, Medication Technician (Med Tech), confirmed that Resident #15's blanket and bed linens were saturated. During an observation on at 11:22 AM, there were no facility staff members present in the memory care unit. Two residents were observed sitting in the main dining area of the memory care unit unattended. Staff B returned to the memory care unit with a lunch cart at 11:24 AM. During an observation on from 1:49 PM to 1:54 PM, there were no facility staff observed in the memory care unit. A resident was observed eating while sitting in the main dining room. During an interview on at 3:52 PM, Staff C, Med Tech, confirmed Resident #15 needed her brief, blanket and linen to be changed	A 025		

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A 025	Continued From page 3 due to saturation. Staff C stated the facility is understaffed, and that makes it harder for the staff providing care. Review of Progress Note electronically signed on by the APRN (Advanced Practice Registered Nurse) revealed Resident #15 has . Plan of care included "unable to leave resident without an assistance person and/or assistive device." Review of facility policy titled, "Care 06-Management for ," dated reads, "Residents suffering with will receive care and management aimed towards restoring whenever possible ...5) Should interventions fail, and the resident is diagnosed with , the Service Plan will include a sound skin management program. Unless contraindicated, residents will receive care and be provided with brief changes." Review of facility policy titled, "Care 02-Personal Care," dated reads, "The resident's hygiene and grooming needs are met while their personal preference and daily routine." During an interview on , at approximately 10:30 AM, Staff A, Med Tech, stated, "It is common not to have the supplies needed to change the residents. We have to go around and look for briefs, and wipes, and sometimes have to borrow them from other residents. We don't have anyone designated to keep track of the inventory. I guess that is why things are like they are. Ever since the kitchen/dining staff were let go, this has put more	A 025		

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A 025	Continued From page 4 of a burden on the care staff to be able to spend the time doing the essential things for the residents. I know we are not providing the kind of care they deserve. We do the best we can, but I get discouraged and almost quit last week because I became so frustrated." During an interview on , at 10:42 AM, Staff F, Med Tech, stated, "I get upset and frustrated in not being able to help the residents as efficiently as they should be. We are scattered and unable to concentrate on the care needs of the residents. Of course, they need to be served their meals and that is important, but by us having to do both work in the kitchen and serve the meals this does take us away from our primary responsibilities. Do residents wait longer than they should to be changed? Yes, they do, especially before lunch and right after meals. This happens in the mornings before and after breakfast and before and after lunch." During an observation of the memory care unit on at approximately 12:50 PM, only one staff member, Staff G, was present. Staff G was observed to be visually upset while waiting for assistance to help change Resident #15. During an interview on at 12:55 PM, Staff G stated, "I called for assistance almost an hour ago to change Resident #15, and I know the staff is expected to be out in the main dining room serving lunch, but this isn't fair to the resident or me because Resident #15 doesn't deserve to lay in wet clothing and bedding, especially for an extended period of time. I have only worked here a short time, but this kind of thing happens too often." On , at 1:10 PM, Staff F was observed	A 025		

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A 025	Continued From page 5 going into the room of Resident #15 to assist Staff G with changing the resident. After care was provided, Staff D returned to the assisted living side of the community, leaving Staff G alone with the 10 memory care residents. During a follow-up interview on . . . . . at 1:45 PM, Staff G stated, "This was not the first time today that I was left waiting for assistance to help change a resident. Earlier, around 11:00 AM, Resident #17, bed needed changing, as well as the resident, and again I waited for assistance. Finally, after waiting over an hour I went ahead and did it myself. This is not right! It isn't fair to the other staff to be tied up with serving meals and helping in the kitchen that the residents in need of care have to suffer and wait for essential care to make them comfortable." On , at approximately 1:50 PM, Resident #17 was observed to be sitting in her wheelchair. Resident #17 was alert and oriented. During an interview on , at 1:50 PM, Resident #17 stated, "Today I waited a long time to be changed. [Staff G's name] is very good and did the job but she really should have help. She is a small lady and could hurt herself, or even me I suppose. This was not the first time." During an interview on . . . . . , at 3:22 PM, the Regional Director of Operations stated, "The kitchen/dining staff had been observed doing a lot of sitting around not doing much of anything. As a result, it was decided we could utilize the care staff to assist in those areas, but it has not been received well by the care staff, so it looks as though we may need to rethink this and make some adjustments."	A 025		

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A 025	Continued From page 6 Class II	A 025		
AN277	59A-36.022(2) FAC LNS - Resident Care Standards (2) RESIDENT CARE STANDARDS. (a) A resident receiving limited nursing services in a facility holding only a standard and limited nursing services license must meet the admission and continued residency criteria specified in Rule 59A-36.006, F.A.C. (b) In accordance with Rule 59A-36.010, F.A.C., the facility must employ sufficient and qualified staff to meet the needs of residents requiring limited nursing services based on the number of such residents and the type of nursing service to be provided. (c) Limited nursing services may only be provided as authorized by a health care practitioner's order, a copy of which must be maintained in the resident's file. (d) Facilities licensed to provide limited nursing services must employ or contract with a nurse(s) who must be available to provide such services as needed by residents. The facility's employed or nurse must coordinate with third party nursing services providers to ensure resident care is provided in a safe and consistent manner. The facility must maintain documentation of the qualifications of nurses providing limited nursing services in the facility's personnel files. (e) The facility must ensure that nursing services are conducted and supervised in accordance with Chapter 464, F.S., and the prevailing standard of practice in the nursing community. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record	AN277		

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AN277	Continued From page 7 review the facility failed to employ or contract with a nurse who coordinates with third party nursing services providers to ensure resident care is provided in a safe and consistent manner. Findings include: During observation on at 9:30 AM, the license posted by the facility read, "State of Florida, Agency for Health Care Administration Division of Health Quality Assurance, Assisted Living Facility Licensed with Limited Nursing Services." Review of the facility's Limited Nursing Services (LNS) folder revealed there was no staff nurse or contract nurse listed. During an Interview on . . . . . at 10:22 AM, the Executive Director confirmed facility did not have a nurse for the LNS license. During an interview on . . . . . at 2:20 PM the Business Manager stated the facility did not have a nurse for LNS. The Business Manager stated Staff D was a License Practical Nurse, but she quit on . . . . . . The Business Manager stated the facility only operates under the standard license and does not utilize the LNS portion of their license. Review of facility records for Staff D revealed a document titled, "Separation Form" that stated Staff D's last day of work was on . Review of facility policy and procedures titled, "GP 29-Limited Nursing Services," dated reads, "Communities holding a Limited Services License may provide services allowable within the scope of their license per	AN277		

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AN277	Continued From page 8 regulations. #4. Facilities licensed to provide limited nursing services must employ or contract with a nurse(s) who must be available to provide such services as needed by residents. The facility's employed or . . . . . nurse must coordinate with third party nursing services providers to ensure resident care is provide in a safe and consistent manner. The facility must maintain documentation of the qualifications of nurses providing limited nursing services in the facility's personnel files." Class III	AN277		