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 _____	07/02/2025

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

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A 000	Initial Comments A complaint (complaint numbers 2025008776 and 2025009196) in conjunction with a generator monitoring survey was conducted at Pacifica Senior Living of Belleair from to . Deficiencies were identified at the time of survey.	A 000		
A 030 SS=G	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline,	A 030		

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A 030	Continued From page 1 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and . ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone	A 030		

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A 030	Continued From page 2 calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence,	A 030		

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A 030	Continued From page 3	A 030		

autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally

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A 030	Continued From page 4 , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state	A 030		

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A 030	Continued From page 5 that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, interviews and a record review the facility failed to honor resident rights for	A 030		

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A 030	Continued From page 6 a safe living environment by not following facility policy after suspected resident . This put 26 residents out of 72 residents residing at the facility at risk for resident-to-resident . Findings included: An observation of the facility grounds on at 9:50 a.m. revealed the facility consisted of a main building and six occupied Cottages ( ). Cottages #4 and #5 were within the same fenced-in area, shared the outside space, and were connected by walkways. The gate to the fenced area was locked and secured with a keypad. A review of the facility's policy on elder , neglect and , , dated , stated if any resident experienced , or when is suspected, staff are required to immediately notify agencies. The policy furthermore showed all staff are mandatory reporters and anybody who had reasonable cause to suspect should right away report the knowledge or suspicion to the central hotline. A thorough investigation would be conducted, and the facility would notify the residents physicians as well. During an interview on at 10:00 a.m. Staff A stated that Staff A was told by another staff member about an incident that allegedly happened on , where resident #11 was on top of resident #6 and when staff pulled Resident #6 off, was noted on his sheets. Staff A stated if she had witnessed or suspected , she would notify management and call the hotline. Staff A had no knowledge of other residents being abused.	A 030		

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A 030	Continued From page 7 During an additional interview on at 4:42 p.m.Staff A stated she didn't know which staff witnessed the incident.Staff A stated she saw in Resident #6's pull-ups at the end of , and reported it to a nurse who no longer works at the facility. Staff A had not seen any more in Resident #6's pull-ups since , . During an interview on at 10:05 a.m. Staff K stated she did not work on but upon return to work Staff K had other people tell her that Resident #6 was seen with . Staff K stated that she told the administrator about the suspected incident around . Staff K also stated she would call the hotline or the state if she would have witnessed . During an interview on at 4:24 p.m. Staff J stated she worked on from 3:00 p.m. to 11:00 p.m., but did not witness anything. Staff J did not see Resident #6 in Resident #11's room. Staff J stated that the incident between Residents #6 and Resident #11 must have happened on the 7:00 a.m. to 3:00 p.m. shift. During an interview on at 5:00 p.m. Staff O revealed that Staff O worked on during the 3:00 p.m.-11:00 p..m shift. Staff O stated she saw Resident #6 in Cottage #4 where Resident #11 resided. Resident #6 who resided in Cottage #5 was seen walking the hallway and hung out frequently in Cottage #4. Staff O never saw Resident #6 in Resident #11's room and never noticed any . , Staff O stated she was told by Staff E on to keep Resident's #6 and Resident #11 separated. Staff O also stated that	A 030		

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A 030	Continued From page 8 she was told Friday by the Sales director and the Business Office Manager to keep them separated. During an interview on at 5:30 p.m. Staff P stated Resident #11 allegedly did inappropriate things to resident #6 early in , before . Staff P did not witness anything but went by hearsay. Staff P stated that staff involved should have called the police. Staff P confirmed she told staff on to keep Resident #6 and Resident #11 separated. Staff P also stated she never found out which staff member actually witnessed an alleged incident. During interviews conducted between at 2:30 p.m. and at 9:00 a.m. Staff S and Staff T stated they were both told by other employees that they had reported an incident between residents #6 and Resident #11 to the Administrator at an unknown date, but the employees felt the Administrator did not listen to their concerns. A record review of resident #6's medical chart, conducted on between 9:00 a.m. and 5:30 p.m., did not reveal evidence of any incident report. Resident #6's health assessment form dated had a diagnosis of Advanced . Resident #6's status was documented as advanced , , and lack of appropriate judgement. An observation of resident #6 between 9:00 a.m. and at 1:30 p.m. revealed Resident #6 was pleasantly .	A 030		

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A 030	Continued From page 9 A record review of Resident #11's medical chart conducted on between 9:00 a.m. and 5:30 p.m. revealed Resident # 11 was independent with all activities of daily living and had no diagnosis of . There was no evidence found that the facility completed an incident report or documented any progress notes for an alleged incident. During an interview on at 2:05 p.m. the Administrator stated an incident between residents #6 and Resident #11 was brought to her attention, but the Administrator had not called the hotline or notified the Agency for Healthcare Administration of a suspected resident-to-resident . The administrator was unable to provide evidence of an incident investigation. Class II	A 030		