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 _____	05/13/2026

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

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A 000	Initial Comments An unannounced Relicensure, Complaint(#2025003672, #2025000970, and #2025012224) and Generator Monitoring survey was commenced on and concluded on for Pacifica Senior Living of Palm Beach. The complaints were not substantiated. Deficiencies related to the relicensure were identified at the time of survey.	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 or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . 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 , , 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 services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal	A 025		

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A 025	Continued From page 1 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, it was determined the facility failed to provide personal supervision, care and services as required by their internal supervision policies and as necessary to ensure the facility adequately monitored resident safety, health and well-being in 1 of 2 sampled residents (Resident #11). The findings included:	A 025		

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A 025	Continued From page 2 Review of the policy for the facility titled, Resident Care, Staffing Standards dated 2024 revealed the following information: All KSL communities shall have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with resident contracts, and the resident Assessment/Care Plans and state specific regulations. Review of the policy for the facility titled, Resident Checks, dated 2024 revealed the following information: To ensure the well-being of all residents, each resident will be observed and accounted for throughout the day by the care manager. The Director of Resident Care will provide the care managers with the Resident Check Report daily. A review of the record for Resident #11 revealed the following information: In a Resident Health Assessment dated activities of daily living were rated as requiring Assistance for Ambulation, Bathing, , Grooming, Toileting, Transfer and requiring Supervision for Eating. Special Diet was specified as other, mechanical soft diet, thin liquids.Hospice visit note for described Hospice Nurse's observation of a incident with Resident #11 and noted concerns of potential , after Resident #11 was given regular diet meal. Note stated Resident #11 was observed seated at a dining table eating breakfast. Resident #11 appeared pleasant, alert to self and place and in no acute distress at the start of visit. Resident #11 was observed to eat eggs without difficulty; however upon attempting to eat bacon, Resident #11 immediately began coughing followed by episode. Food intake was immediately stopped, Resident #11 was assisted to their room for further assessment	A 025		

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A 025	Continued From page 3 and monitoring, and education on , precautions and the importance of soft diet compliance and monitoring during meals was provided to facility staff. In an interview on at approximately 1:15 pm with Staff B (Director of Nursing), it was reported a minimum of 9 caregivers and/or med techs are scheduled per shift. It was stated this allowed for 2 dedicated staff each in Cottage 2 & Cottage 5, 1 dedicated staff each in Cottage 4, Cottage 6 and Cottage 7 and 2 staff that float. In a confidential staff interview on at approximately 1:30 pm, it was reported that in the last few months staffing was reduced from a previous standard of 2 dedicated staff in each Cottage on all shifts. Staff identified this reduction has made providing appropriate care and supervision difficult. In an interview on at approximately 3:15 pm, in an interview with Staff B (Director of Nursing) it was reported resident status checks are not consistently completed and when conducted they are not tracked or charted. It was also reported there is no rounding schedule. In an interview on at approximately 3:20 pm with Staff A, it was reported that the emergency call lights and pull do not function, have not in a long time and there is no plan to make them functional. Observations made on - between the hours 8:00 am and 4:00 pm revealed the facility was not in compliance with their internal policies for supervision written with the intention of meeting care and services needs for residents. The following concerns were identified:	A 025		

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A 025	Continued From page 4 On at approximately 8:20 am, Surveyor arrived on site. There were no staff in the Administration office and the building was locked. Surveyor accessed Cottage 4 with assistance of a member of housekeeping staff. Upon entry, Surveyor observed Staff O (Caregiver) serving breakfast to residents. Staff O reported she was the only dedicated staff member in Cottage 4 on this shift to serve meal and provide care and services. On at approximately 9:30 am a Hospice Nurse arrived to assist Resident #11 and made a statement regarding Resident's ankles. In an interview at the time, the Hospice Nurse reported that Resident #11 should be wearing his , socks when up. A review of Resident #11's file revealed an order dated which stated , stockings were to be applied to BLE (lower extremities) in the morning and removed in the afternoon. Certified Nursing Assistant (CNA) may apply & remove. On at approximately 12:00 pm observed Staff E provide lunch service in Cottage 2. Staff E was observed to serve Resident #11 soup from same hotel pan as other residents. In an interview at the time of the meal service, Staff E was asked how she knew which residents required special diets. Staff E stated she just does. Staff C (Food Service Manager) entered Cottage 2's dining area. In an interview at the time of the meal service, Staff C confirmed there should be special diets list posted or available for Cottage staff to refer to. Staff C checked and reported there is not one in Cottage 2. Staff E continued lunch service and Resident #11 was served a plated meal from same hotel pans as	A 025		

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A 025	Continued From page 5 other residents - chicken salad containing large chunks of chicken, bean salad with whole beans and half of a pita bread cut in half. No assistance was offered or provided to Resident #11 during the meal. In an interview with Staff C it was stated that the kitchen does not alter mechanical soft meals and relied on care staff to accommodate residents requiring them. Surveyor asked how care staff could do this if they did not have a list of residents requiring special diets. Staff C did not answer this inquiry. Resident #11 required a special diet accommodation of a mechanical soft diet. This was ordered on the Health Assessment and reinforced by Hospice Nurse on due to concerns with ; however, the facility failed to accommodate Resident #11's dietary needs. On at approximately 9:20 am, Staff F (Caregiver) was observed attempting to start the concentrator for Resident #11 who had requested it and was seated at a table in the dining area. Staff E (Caregiver) stopped Staff F from turning on the machine. Surveyor inquired why and Staff E reported she was told by the nurse not to turn it on. On at approximately 12:00 pm, Hospice Aide arrived to assist with Resident #11 with activities of daily living care. Upon interview at the time, Hospice Aide reported a plan to shower Resident #11. Hospice Aide called for a Caregiver to help as Resident #11 required 2 person assistance. There were no staff available to assist. Hospice Aide asked Caregivers why Resident 11's was not on him, called the hospice agency to confirm Resident #11 should be receiving it and then went to find a nurse to titrate it. A Nurse arrived to assist at approximately 12:35 pm and was observed	A 025		

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A 025	Continued From page 6 checking Resident 11's ,,, level. Resident #11 had requested his ,,, at 9:20 am from facility staff. It was not turned on for him until 12:35 pm and required hospice's intervention to do so. On at approximately 12:05 pm, Resident #11's plated meal was delivered from the kitchen. Hospice Aide informed care staff she was available to feed Resident, but food was not given to her as only care staff on duty Staff E reported she was busy assisting other residents. At approximately 12:15 pm Resident #11 was wheeled by his Hospice Aide to a table in the dining area. At approximately 12:20 pm, Staff E microwaved Resident #11's food (mechanical soft plate) and placed it in front of him; however, no staff was available to help him eat. At approximately 12:35 pm Resident's Hospice Aide arrived to feed him. Resident #11 was observed to refuse his food. Interview and observations made throughout the survey identified a lack of facility's compliance with internal policies on supervision as well as a lack of coordination of care with hospice services. In multiple observed instances (, stockings, ,,, concentrator, feeding assistance), care was not provided to Resident #11 until hospice services arrived and intervened on Resident's behalf. In one case, that of special diet requirements, despite intervention from hospice, the facility continued to fail to meet Resident #11's needs. Interviews with staff identified a recent reduction in staffing as a potential reason for this failure. Class III	A 025		

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A 036	Continued From page 7	A 036		
A 036	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure staff utilized control procedures including hygeine before, during and after medication pass. The findings included: On from 9:14am to 9:35am, Surveyor	A 036		

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A 036	Continued From page 8 observed medication passes conducted by Staff K (Medication Technician) for Residents #17, #18 & #19. Staff K was observed to wear the same pair of gloves throughout the three medication passes. Staff K was observed touching multiple surfaces including a computer keyboard, the medication cart, keys, a table in the dining room and Residents #18 and #19 before passing medications. On at approximately 10:35am in an interview, Staff B (Director or Nursing) reported awareness that no hygiene was conducted during observed medication passes. On at approximately 5:00pm in an interview with Staff A (Administrator) and Staff B, concerns about lacking control procedures were outlined. Staff B acknowledged concerns. Class III	A 036		
A 053	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record.	A 053		

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A 053	Continued From page 9 (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, it was determined that, the facility failed to ensure that only licensed care staff administered medication. The findings included: On at approximately 9:20 am, Surveyor observed medication pass with Staff K (Medication Technician.) Staff K reported plan to crush medications for Resident #19. Staff K reported sometimes I crush them, sometimes I don't. I give them to her crushed and (Resident) says she wants them big. Surveyor observed	A 053		

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A 053	Continued From page 10 Staff K crush medication (-S 8.6MG - 50MG), mix it into applesauce and feed it to Resident #19. Medication was not announced. A record review of the Medication Observation Record for Resident #19 revealed the following: -S 8.6MG-50MG Tab Take 2 tablets (17.2-100MG) by once daily Review of the medication label for Resident #19 revealed the following: -S 8.6-50MG Take 2 tablets (17.2-100MG) by once daily A record review of the document provided titled Informational Orders, Categories: crush medication, Crush medications, Crush order dated for the facility revealed the following: The list included 23 residents including Resident #19. The order for all stated , crush appropriate medications. In an interview at approximately 1:45 pm with Staff B (Director of Nursing) it was reported facility staff passing medication, including unlicensed care staff, are the ones determining which medications are appropriate to crush. Additionally, Staff B advised there are no waivers for announcing of medications for any residents. On at approximately 5:00 pm, in an interview with Staff A (Administrator) and Staff B, concerns regarding medication administration (spoon-feeding medication, not announcing medications, determining which medications to crush) by an unlicensed caregiver were outlined. Staff B acknowledged concerns. Class III	A 053		

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A 200	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related	A 200		

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A 200	Continued From page 12 injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in Section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to Chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details	A 200		

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A 200	Continued From page 13 regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to Section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the	A 200		

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	AL11964922	A. BUILDING: _____ B. WING _____	05/13/2026

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

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A 200	Continued From page 14 amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (b) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the county emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within 30 days of the approval of the plan	A 200		

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A 200	Continued From page 15 from the county emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration to assistedliving@ahca.myflorida.com. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the county emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . , have implemented the plan required under this rule. (b) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (c) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power	A 200		

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A 200	Continued From page 16 source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this	A 200		

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A 200	Continued From page 17 rule, the Agency for Health Care Administration may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon the initial submission of the plan to the county emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. 3. Annual submissions and approvals of the plan do not require notification to residents or their legal representatives unless a significant modification as defined in Rule 59A-36.019, F.A.C., has been made to the plan. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For	A 200		

Agency for Health Care Administration

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A 200	Continued From page 18 purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure a functioning monoxide detector was installed on site. The findings included: In observations made from - from 8:00 am until 4:00 pm on tour of the facilities multiple buildings, no monoxide detectors were seen. In an interview at approximately 3:00 pm with Staff A (Administrator), it was reported there are no monoxide detectors at the facility. Class III	A 200		