

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER VILLA OF KINGS & QUEENS OF DELRAY BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 13415 BARWICK RD DELRAY BEACH, FL 33445		
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A 000	Initial Comments An unannounced licensure complaint survey, (#2020016896), and a Focused Control survey was conducted from _____ to _____ at Villa of Kings and Queens of DeLray Beach. The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=J	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 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 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 (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 record review, interview and observations, it was determined that the facility failed to ensure appropriate supervision was provided to each resident as it relates to their diagnosis, care needs and physician orders for the use of bed rails. As evidenced by the facility's failure to ensure its direct care staff were continually evaluating and supervising the use of bed rails for 5 out of 10 residents (Residents #4, 5, 6, 8 and 10) who were prescribed the use of bed rails for positioning. The facility also failed to provide appropriate supervision of care to its residents which resulted in 1 out of 10 sampled residents (Resident #10) being allowed to	A 025			

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A 025	Continued From page 2 perform transfers and to eat independently while in bed. These systematic failures likely caused Resident #10 to partially off the bed and sustain injuries that led to the resident's on The findings included: Review of the facility's " Prevention Policies and Procedures", (undated) indicated that the facility staff was responsible to implement safety interventions to reduce the incidence of resident Review of this policy revealed that a . . . was considered to be an unplanned descent to the floor or the next lower surface and continued assessment and monitoring will occur until each resident is no longer considered a risk for Review of the facility's policy titled "Bed Rail Policies and Procedures", (undated) indicated that the facility staff was responsible to identify and reduce safety risks and hazards associated with each resident's bed rail use. Review of this policy indicated that the facility was responsible for ensuring individual resident bed rail evaluations to improve each resident's care planning and positive outcomes. Review of U.S. Food and Drug Administration (FDA) website on (revised on) documents the following. Bed rails are used by many people to help create a supportive and assistive sleeping environment in homes, assisted living facilities and residential care facilities. Many and injury reports related to entrapment and . . . for both adult portable bed rail products and hospital bed rails have been reported to the U.S. Consumer Product Safety Commission (CPSC) and the U.S. Food and Drug Administration (FDA). Adult bed	A 025		

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A 025	Continued From page 3 rails should not be used as a They are intended to be assistive and should be used to facilitate mobility for those who need assistance getting in and out of bed or repositioning in bed. All bed rails should be used with caution, especially with older adults and people with physical limitations and certain medical conditions. During an interview with the Administrator on at 11:50 AM, she stated that it is the facility's policy that staff monitor the resident's at night every 4 hours and while in bed. Upon request of this policy; the Administrator, stated that this is a verbal policy and no written documentation was available for review. Further interview with the Administrator, revealed she currently has 4 residents (Resident Residents #4, #5, #6 and #8) that use bedrails. She stated, Resident #10 also used bedrails while in the bed until her She stated, the bedrails were used while the residents were in the bed and at night while sleeping to prevent and for safety. She also confirmed that the residents were not capable of lifting the rails up or down independently. She also confirmed that all 9 residents (Resident #1-#9) require supervision with their daily Activities of Daily Living (ADLS) and oversight with their general well-being. She also stated, that Resident #10 required supervision with her daily Activities of Daily Living (ADLS) and oversight with general well-being. Review of Resident #10, #4, #5, #6 and #8's file revealed, all the resident's required assistance and supervision with their ADLs and had a physicians order for bedrails for positioning. Further review of the residents' records also revealed that based on the resident's status, additional supervision was required with	A 025		

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A 025	Continued From page 4 the use of bed rails to prevent entrapment and ensure the safety of the resident while in use. Review of the resident files and observations conducted on _____ thru _____ revealed the following: a) Resident #10's record indicated that she was admitted to the facility on _____. Review of the resident's health assessment Agency for Health Care Administration (AHCA) Form 1823 dated on _____ indicated that the resident was diagnosed with _____ (_____), _____'s _____ and _____. Review of this health assessment indicated that the resident had gait abnormalities, was depressed and required _____ precautions. Further review of this health assessment indicated that the resident needed assistance with ambulation, bathing, _____ grooming, toileting and transferring, and needed supervision with eating. Review of the resident's physician order dated on _____ indicated that the resident required "_____ side rails for positioning" and this order was signed by the resident's nurse practitioner and the administrator. Review of this record indicated that there was no resident bed rail evaluation conducted by the facility within this record. An interview with the Administrator on _____ at 11:55 AM, revealed that the resident was forgetful. However, this _____ status was not documented on the resident's health assessment. The administrator admitted the bed rail evaluation was not completed for resident #10. The Administrator was also questioned regarding the _____ precautions, the facility had implemented for Resident #10. She stated the facility had implemented 4 hour checks (verbally implemented) and the bed rail for safety.	A 025		

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A 025	Continued From page 5 However, the Administrator was not able to provide documentation regarding monitoring Resident #10 as noted in the facility's policy and procedure. In an observation of Resident #10's bed on at 2:00 PM, Resident #10's bed did not have any bed rail installed. However, the bed was placed against the wall on the right side of the bed. In an interview with the Administrator at this time, she stated that Resident #10's bed rail was removed after the incident on . The Administrator directed the surveyor to Resident#5's bed to demonstrate the exact location of Resident#10's bed rail prior to removal. Based on the example, provided by the Administrator; Resident #10's bed would have had openings at the and of the bed, the bedrail was positioned in the middle of the bed, on the left side of the bed. The bed rail was observed to have gaps in between the mattress and the side-rail which poses a potential entrapment risk. (Photographic evidence obtained) During an interview with the Administrator on at 11:50 AM, she stated that Resident #10 was found by Staff B (direct care staff) on after the resident experienced an accident while on her bed. She stated that on at about 5:35 AM, staff B saw the resident's lower extremities on the bed and her upper torso was bent over the left side rail of the bed, with the resident's touching the floor. She stated that the resident's bed side rail was raised about halfway on the left side of the resident's bed and the resident's lower extremities were against the bed side rail when Staff B found the resident on . She	A 025		

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A 025	Continued From page 6 stated that Staff B attempted to get a verbal response from Resident #10 and the resident did not respond. In an interview with Staff B (direct care staff) on at 12:35 PM, she stated that she started her shift on at 11:00 PM. She stated, she checked on Resident #10 on at about 1:00-1:30 AM and the resident was resting at that time in bed. She stated that she usually checked every resident during the night about every 4 hours (before), regardless of their bed rail use or activities of daily living status. She stated that Resident #10 liked to snack on cookies in her bed and she usually kept the cookies in her nightstand which was located next to her bed. She stated that the resident's family member usually got her the cookies and the resident usually grabbed the cookies on her own whenever she liked during the night. When the staff was questioned about Resident #10 eating cookies without supervision, the staff stated they were aware the resident required the assistance, but they allowed her to consume the cookies independently without supervision and assistance. She stated that she found the resident bent over the side rail of the bed on at about 5:35 AM with her lower extremities on the bed and her touching the floor. She stated that Resident #10 used the bed side rail, so she didn't out of the bed when sleeping and the bed side rail was elevated when she found the resident on . She stated that she checked for the resident's at that time, and the resident had no . She stated that the resident was likely trying to get her cookies earlier that morning from her nightstand when she over the side of the bed because the cookie box was on the floor as well. She	A 025			

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A 025	Continued From page 7 stated that Staff C (direct care staff) was working with her on _____ and she called on her right after she found Resident #10 at 5:35 AM. In an interview with Staff C on _____ at 12:15 PM, she stated that on _____ at about 11:00 PM, she checked on all residents while they were sleeping and then she went to sleep. She stated that she woke up on _____ at around 5:30 AM to assist Resident #6, whose room was next to Resident #10's room. She stated that a few minutes after this, Staff B called on her to come see Resident #10, who was bent over the bed side rail with her _____ touching the floor. She stated that she checked on the resident's _____, but the resident was unresponsive and had no _____, and then staff B called the administrator on the phone. She stated that she and Staff B lifted the resident to position her on the bed. In an interview with a local Police Detective on _____ at 9:15 AM, he stated that he was conducting the investigation relating to Resident #10 being found unresponsive by the facility staff and subsequently declared _____ by the Emergency Medical Services (_____) staff. He stated, that based on his consultation with the medical examiner investigator, the resident (Resident #10) suffered positional asphyxia (Definition-a critical condition arising out of _____ body positions leading to mechanical obstruction of _____. The American Journal of Forensic Medicine and _____ volume 37) which led to her _____ and that this was still under investigation by the medical examiner's office. Review of the police report dated on _____ at 7:30 AM, indicated that resident #10's bedroom had two _____ beds on opposing sides	A 025		

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A 025	Continued From page 8 with nightstands in the middle. The room was neat and organized. There was an opened container of fig newton cookies on the floor and a few loose cookies near the resident's bed but there were no signs that a struggle occurred in the room. The guard rail on the bed was what kept the resident from completely falling off. The resident was lying on the east bed covered by a bedsheet. In an interview with the Medical Examiner Investigator on _____ at 1:10 PM, he stated that based on the evidence gathered at the facility on _____, resident #10 was found wedged on the side bed rail and this likely hampered her breathing which led to her _____. He stated that this was exacerbated due to her compromising diagnoses of _____ and _____. He stated that the resident was suspected to have _____ on _____ due to positional asphyxia. He stated that the resident's body is in process of undergoing toxicological and histological examinations through the medical examiner's office. b) Review of Resident #4's health assessment/AHCA Form 1823 dated on _____ indicated that she was diagnosed with unstable gait, _____ and poor memory. Further review of this health assessment indicated that the resident needed assistance with ambulation, bathing, _____, toileting and transferring, and needed supervision with grooming. Review of the resident's physician order dated on _____ indicated that the resident required "_____ side rails for positioning" and this order was signed by the resident's Nurse Practitioner and the	A 025		

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A 025	Continued From page 9 Administrator. Review of this record indicated that there was no resident bed rail evaluation within this record conducted by the facility. In an observation of Residents #4's bedroom on _____ at 2:15 PM, Resident #4's bed rail was installed and lowered on the bed's left side. During this observation, it was noted that this bed was placed against the wall on the right side of the bed and the lowered bed rail was positioned towards the _____ of the bed. The bed rail had gaps in between the mattress and the side-rail which poses a potential entrapment risk. (Photographic evidence obtained) c) Review of Resident #5's health assessment/AHCA Form 1823 dated on _____ indicated that she was diagnosed with _____ deficiency, _____, history of diverticular _____, unstable gait, history of _____, and had poor short term memory. Further review of this health assessment indicated that the resident needed _____ precautions and needed assistance with bathing, _____, toileting and grooming, and needed supervision with eating. Review of the resident's physician order dated on _____ indicated that the resident required "_____ side rails for positioning" and this order was signed by the resident's Nurse Practitioner and the Administrator. Review of this record indicated that there was no resident bed rail evaluation or _____ assessment within this record conducted by the facility. In an observation of Resident #5's bedroom on _____ at 2:00pm, Resident #5's bed rail was installed and raised on the bed's right side and positioned in the middle section of the bed. The bed was placed against the wall on the left side of the beds. During this observation, it was noted that the raised bed rail on Resident #5's bed, had openings at the _____ and _____ of	A 025			

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A 025	Continued From page 10 the bed. The bed rail had gaps in between the mattress and the side-rail which poses a potential entrapment risk. (Photographic evidence obtained) d) Review of Resident #6's health assessment/AHCA Form 1823 dated on _____ indicated that he was diagnosed with _____'s _____, prostatic hyperplasia, _____ of _____, difficulty walking, _____ and _____. Further review of this health assessment indicated that the resident needed assistance with all activities of daily living. Review of the resident's physician order dated on _____ indicated that the resident required "side rails for positioning" and this order was signed by the resident's Nurse Practitioner and the Administrator. Review of this record indicated that there was no resident bed rail evaluation within this record conducted by the facility. In an observation of Residents #6's bedroom on _____ at 2:10 PM, Resident #6's bed rail was installed and raised on the bed's left side and the resident was lying on his bed and being seen by a hospice staff member at this time. The rail had gaps in between the mattress and the side-rail which poses a potential entrapment risk. (Photographic evidence obtained) e) Review of Resident #8's health assessment/AHCA Form 1823 dated on _____ indicated that she was diagnosed with _____, gait instability, _____, agitation, poor short-term memory and was a _____ risk. Further review of this health assessment indicated that the resident needed assistance with ambulation, bathing, _____, toileting, grooming and transferring. Review of the resident's physician	A 025		

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A 025	Continued From page 11 order dated on _____ indicated that the resident required "Full side rails for positioning" and this order was signed by the resident's Nurse Practitioner and the Administrator. Review of this record indicated that there was no resident bed rail evaluation or assessment within this record. In an observation of Residents #8's bedroom on _____ at 2:20 PM, resident #8's bed rail was installed and lowered on the bed's left side. During this observation, it was noted that this bed was placed against the wall on the right side of the bed and the lowered bed rail was approximately _____ length of the bed and was positioned in the middle section of the bed. The bed rail had gaps in between the mattress and the side-rail which poses a potential entrapment risk. (Photographic evidence obtained) In an attempt to interview Resident #5 on _____ at 9:50 AM, the resident presented to be _____ and unable to hold a conversation at this time. In an attempt to interview Resident #4 on _____ at 1:00 PM, the resident presented to be _____ and unable to hold a conversation at this time. In an attempt to interview Resident #8 on _____ at 1:05 PM, the resident presented to be _____ and unable to hold a conversation at this time. In an interview with the Administrator on _____ at 1:25pm, she stated that the purpose for the use of bed rails for Resident #10 and all the other residents (#4, #5, #6 and #8) in facility was "for safety." She stated that the residents felt better with bed rails up while sleeping so they don't off the bed and that none of the residents were able to move the bed rails on their own. She stated that the Nurse Practitioner provided orders for all the residents (#4, #5, #6, #8 and #10) who	A 025		

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A 025	Continued From page 12 used bed rails and she understood that the indication for these orders were for the safety of the residents as she described. She stated that she did not have any current resident bed rail evaluations conducted by the facility. She stated that the residents in the facility used to be monitored by the staff during the overnight shifts every 4 hours before . This indicated that in between these overnight monitoring periods the facility residents who used bed rails and ate snacks did not receive direct supervision from the staff. She stated that the facility staff was presently monitoring residents during the overnight shifts every 2 hours in light of the event on . and she felt this was sufficient to ensure all the residents' health, safety and well-being. No documentation was provided for resident monitoring for the 2 hour or 4 hour checks. In an interview with Resident #10's Nurse Practitioner on at 9:40 AM, he stated that he was familiar with Resident #10's medical care and that he ordered a half bed rail for the resident's use in the facility on . He stated that what he meant by "for positioning" in this order, was for the resident's use of this bed rail as an assistive device with a staff member present to provide assistance to reposition the resident while in the bed. He stated that he believed that the Administrator, who was a licensed nurse, understood the meaning of his resident bed rail orders as written and that the facility did not ask him for any further instructions at any time for the resident's use of the bed rails. Review of the photographic evidence emailed by the facility to the AHCA Surveyor on at 4:32 PM indicated that Resident #10 was found by staff B and C wedged on the side of the bed	A 025		

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NAME OF PROVIDER OR SUPPLIER VILLA OF KINGS & QUEENS OF DELRAY BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 13415 BARWICK RD DELRAY BEACH, FL 33445		
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A 025	Continued From page 13 rail with her lower extremities on the bed against the bed rail and her torso flexed at the , with her on the floor. Review of this photo indicated that the resident's right upper extremity was beside her torso and left upper extremity was flexed at approximately 90 degrees touching the floor. Further review of this photo indicated that there were dark red stains on the bed and pillow, the nightstand lower drawer was partially opened, and the cookies were inside their container on the floor next to the resident's . Further interview with the Administrator on at 4:45 PM, revealed the facility has not updated any of its policy with respect to bedrails, supervisions and . The facility also confirmed that Staff B and Staff C are still employed with the facility. The Administrator confirmed that the elements of adequate supervision with respect to each resident's care needs and the use of bedrails have not been reassessed to ensure the safety and well-being of the residents currently residing in the facility, including the 4 residents (residents #4, #5, #6 and #8) that use bedrails. Class I		A 025		
A 030 SS=J	59A-36.007(6) FAC; 429.28() FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) 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		A 030		

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A 030	Continued From page 14 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, 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 universal precautions; and,	A 030		

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A 030	Continued From page 15 8. The requirements for coordinating the delivery of services to residents by third party providers. (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 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. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical _____ by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical _____. 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	A 030		

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A 030	Continued From page 16 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, 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.	A 030		

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A 030	Continued From page 17 (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, 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	A 030		

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A 030	Continued From page 18 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 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	A 030		

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A 030	Continued From page 19 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 interview and record review, the facility failed to honor the rights of 1 of 10 sampled residents (Resident #10) by failing to perform () when the resident was found unresponsive by facility staff members on , and the resident did not have a () to withhold her life sustaining treatment. The facility currently had 6 residents (Residents #1, #2, #3, #5, #7 and #9) whom did not have a valid . The findings included: Review of the facility's Advance Directives and policies and procedures (undated) indicated that the facility staff was responsible to include an indication of each resident's status in their record. Review of this document indicated that if a was executed for a resident, this will be provided to every resident service provider and the facility will follow every resident's wishes relating to advance directives and .	A 030	

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A 030	Continued From page 20 Review of the adverse report submitted by the facility to the Agency for Healthcare Administration on at 5:58 PM revealed the following. 1) Resident name (R#10), the incident occurred on at 0535 in the resident/patient room. Outcome is and an event report to law enforcement or its personnel for investigation. The report documents the Administrator (licensed personnel, Registered Nurse) and Caregiver B (unlicensed personnel, Direct Care Staff) involved in the incident. On (5:58 PM) the report documents the following: The people involved in the incident were [the Administrator, RN] and [Direct Care Staff B] on at about 5:35 AM, while [Staff B] was making her rounds the resident was found in her room against the bed side rail with leaning forward and touching the floor. It appears that the resident was reaching for cookies that had to the floor while in bed. The resident was unable to bring herself to normal position in the bed. [Staff B] checked the resident and she was unresponsive. [Staff B] then contacted [the Administrator] at about 5:40 AM and the administrator reached the facility at about 5:50 AM. The administrator re-examined the resident and called 911. At about 6:05 AM, The ambulance from fire rescue came and examined the resident and declared the resident The police arrived at about 6:10 AM. Resident #10's family was eventually reached and notified at about 6:22 AM. The resident was transported to the Medical Examiner Office for an autopsy at about 9:40 AM. The Police Detective arrived on the scene around 7:50 AM to begin his investigation. The Medical Examiner arrived around 9:24 AM, the resident was transported to the Medical Examiner Office for an autopsy at around 9:40 AM.	A 030		

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A 030	Continued From page 21 2) Adverse incident report update submitted by the facility on _____ documented the following: _____ was not initiated because resident had signs of irreversible _____. The resident did not have a _____. 3) Analysis documented as _____ at 11:27 AM, submitted by the facility. The incident occurred on _____ at about 5:35 AM, while staff [Staff B] was making her rounds resident was found in her room against the bed side rail with _____ leaning forward and touching the floor. The reason it occurred is because it appeared that the resident was reaching for cookies that had _____ to the floor while in bed. Resident was unable to bring herself _____ to a normal position in the bed. [Staff B] checked the resident and she was unresponsive. 4) Correction Action submitted on _____ at 11:42 AM documented as the following: In order to prevent this type of occurrence, we have instructed the staff to check each resident every two hours instead of 4 hours. This would allow us to better react should a situation like that arises. We have removed any items on side table that may cause residents to reach for items on the side table. Resident #10's record indicated that she was admitted to the facility on _____. Review of Resident #10's health assessment dated on _____ indicated that the resident was diagnosed with _____ (_____) _____'s _____ and _____. Review of this health assessment/AHCA Form 1823 indicated that the resident had gait abnormalities, was depressed and required _____ precautions. Further review of this health assessment indicated that the resident needed assistance with ambulation, bathing,	A 030	

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A 030	Continued From page 22 ... grooming, toileting and transferring, and needed supervision with eating. Review of the resident's physician order dated on ... indicated that the resident required " ... side rails for positioning" and this order was signed by the resident's nurse practitioner and the administrator. Review of this record indicated that the resident did not have any valid In an interview with the Administrator (a licensed Registered Nurse) on ... at 11:50 AM, she stated that Resident #10 was found by Staff B (unlicensed direct care staff) on ... after the resident experienced an accident while on her bed. She stated that on ... at about 5:35 AM, Staff B saw the resident's lower extremities on the bed and her torso was bent over the side rail of the bed, with the resident's ... touching the floor. She stated that the resident's bed side rail was raised about halfway on the left side of the resident's bed and the resident's lower extremities were against the bed side rail when staff B found the resident on ... She stated that Staff B attempted to get a verbal response from Resident #10 and the resident did not respond. She stated that Staff B then checked for a ... on the resident, to which she found no ... Then, Staff B proceeded to lift the resident onto the bed. She stated that Staff B then called her on ... at about 5:35 AM and she told Staff B to perform ... () on the resident. She stated, Staff B told her that the resident was "too far gone" to receive ... indicating that staff B declared the resident to be ... She stated that since she was a few minutes away from the facility, she told Staff B to wait for her. She stated that once she arrived at the facility on ... at about 5:50 AM, she found the resident side lying on the bed and she checked the resident's ... to which she found	A 030		

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A 030	Continued From page 23 no She stated that she immediately called 911 for emergency medical services () to arrive onsite. She stated that after . . . arrived on . . . at about 6:05 AM, the . . . staff declared the resident . . . and that it was an irreversible . . . by the time they arrived. During this interview, the Administrator did not include the direct involvement of any other staff members during this event on In an interview with the Administrator on at 12:10 PM, she stated that she and all the facility staff were . . . trained and that . . . was allowed and required to be performed on unresponsive residents whom did not have a valid She stated that presently there were 6 residents (Residents #1, #2, #3, #5, #7 and #9) whom did not have any . . . and that Resident #10 also did not have a valid She stated that all staff members were aware of this and that she felt that Staff B was trained to make the decision of Resident #10 being "too far gone" but she still preferred that all her staff members performed . . . on all unresponsive residents in the facility without At this time, the Administrator was requested to provided documentation indicating that Staff B had training and licensure status qualifying her to make the decision to declare a resident In an interview with Staff B on at 12:35PM, she stated that she started her shift on at 11:00 PM, she checked on Resident #10 on at about 1:00-1:30am and the resident was resting at that time. She stated that she usually checked every resident during the night about every 4 hours before regardless of their bed rail use or activities of daily living status. She stated that Resident #10 liked to snack on cookies and she usually kept	A 030		

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A 030	Continued From page 24 the cookies in her nightstand which was located next to her bed on the left side near the upper top portion of the residents bed. She stated that the resident's family member usually got her the cookies and the resident usually grabbed the cookies on her own whenever she liked during the night. She stated that she found the resident bent over the side rail of the bed on _____ at about 5:35AM with her lower extremities on the bed and her _____ touching the floor. She stated that Resident #10 used the bed side rail so she didn't _____ out of the bed when sleeping and the bed rail was elevated when she found the resident on _____. She stated that she checked for the resident's _____ at that time, and the resident had no _____. She stated that the resident was likely trying to get her cookies earlier that morning from her nightstand when she over the side of the bed because the cookie box was on the floor as well. She stated that she received her _____ certification in _____ and she was taught to perform _____ on unresponsive individuals. She stated that she was scared to perform _____ on Resident #10 and her emotions kept her from initiating _____ on _____. She stated that Staff C (unlicensed direct care staff) was working with her on _____ and she called on her right after she found resident #10 at 5:35am. She stated that she called the Administrator immediately after this and the administrator showed up shortly thereafter. In an interview with the Administrator on at 2:20pm, she stated that she felt that she did not have time to initiate _____ on resident #10 from when she first arrived on _____ at about 5:50am since the _____ staff arrived to the facility at about 6:05am. She stated that she needed about 3 minutes to initiate _____ on any resident	A 030		

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A 030	Continued From page 25 and she could not describe why she was not able to initiate on resident #10 in approximately 15 minutes of time she had on She stated that she felt that the results from the medical examiner, specific to resident #10's time and cause of , would validate staff B's decision to not have initiated on resident #10, because she believed that the resident was the moment staff B found the resident after she from the bed on In an interview with Staff C on at 12:15PM, she stated that on she checked on all residents around 11 PM while they were sleeping and then she went to sleep. She stated that she woke up on at around 5:30AM to assist Resident #6, whose room was next to Resident #10's room. She stated that a few minutes after this, Staff B called on her to come see Resident #10, who was bent over the bed side rail with her touching the floor. She stated that she checked on the resident's, but the resident was unresponsive and had no, and then Staff B called the Administrator on the phone. She stated that staff B and herself lifted the resident to position her on the bed. She stated that she did not perform because she was too emotional and panicked from seeing the resident being unresponsive. She was aware that resident #10 did not have a valid In an interview with the local Police Detective on at 9:15AM, he stated that he was conducting the investigation relating to Resident #10 being found unresponsive by the facility staff and subsequently declared by the staff. He stated that based on his consultation with the medical examiner investigator, the resident suffered positional asphyxia (Definition-a	A 030	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967224	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/21/2020
NAME OF PROVIDER OR SUPPLIER VILLA OF KINGS & QUEENS OF DELRAY BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 13415 BARWICK RD DELRAY BEACH, FL 33445		
(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 030	Continued From page 26 critical condition arising out of _____ body positions leading to mechanical obstruction of _____. The American Journal of Forensic Medicine and _____, volume 37) which led to her _____ and that this was still under investigation by the medical examiner's office. Review of the police report dated on _____ at 7:30AM, it indicated the following regarding Resident #10's case. The resident's bedroom had two _____ beds on opposing sides with nightstands in the middle. The room was neat and organized. There was an open container of fig newton cookies on the floor and a few loose cookies near the resident's bed but there were no signs that a struggle occurred in the room. The guard rail on the bed was what kept the resident from completely falling off. The resident was lying on the east bed covered by a bedsheet. There was a small amount of purge "(vomitus or _____)" on the floor next to resident's bed and a small, dried _____ stain on the resident's nightstand. I removed the sheet covering the resident's _____ and noticed a portion of dried _____ in the resident's hair on the left side of her _____. There were also _____ stains on the pillow that the resident's _____ was resting on. There was a small amount of dried _____ on the resident's _____ as well as visible tardieu spots (Dark pinpoint spots when capillaries _____ due to increased gravitational pressure. Reference Amboss Medical.com) on her _____ and _____. I was unable to visually determine if the resident had an injury on her _____ or not. There were no signs of foul play. The following resident record reviews indicated that there were currently 6 residents (Residents #1, #2, #3, #5, #7 and #9) whom did not have a valid _____.	A 030		

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A 030	Continued From page 27 Review of Resident #1's health assessment(AHCA form 1823) dated on _____ indicated that he was diagnosed with _____ prostatic hyperplasia, _____ and poor short term memory. Further review of this health assessment indicated that the resident needed supervision with bathing. Review of this record indicated that the resident did not have any valid _____ Review of Resident #2's health assessment(AHCA form 1823) dated on _____ indicated that he was diagnosed with _____, meningioma, _____ delay and _____. Further review of this health assessment indicated that the resident needed assistance with bathing and _____ and needed supervision with grooming and toileting. Review of this record indicated that the resident did not have any valid _____ Review of Resident #3's health assessment(AHCA form 1823) dated on _____ indicated that he was diagnosed with _____ and collapse, _____. Further review of this health assessment indicated that the resident needed assistance with ambulation and needed supervision with bathing, _____ grooming, toileting and transfers. Review of this record indicated that the resident did not have any valid _____ Review of Resident #5's health assessment(AHCA form 1823) dated on _____ indicated that she was diagnosed with _____ deficiency, _____, history of diverticular _____	A 030		

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A 030	Continued From page 28 , unstable gait, history of, and had poor short term memory. Further review of this health assessment indicated that the resident needed precautions and needed assistance with bathing, ... toileting and grooming, and needed supervision with eating. Review of this record indicated that the resident did not have any valid Review of Resident #7's health assessment(AHCA form 1823) dated on indicated that she was diagnosed with and memory problems. Further review of this health assessment indicated that the resident needed assistance with all of her activities of daily living and total physical assistance with bathing. Review of this record indicated that the resident did not have any valid Review of Resident #9's health assessment (AHCA form 1823) dated on indicated that she was diagnosed with, gait instability and poor short term memory. Further review of this health assessment indicated that the resident needed assistance with ambulation, bathing, ... and toileting, and needed supervision with grooming and transfers. Review of this record indicated that the resident did not have any valid In an interview with the Administrator on at 3:00PM, she stated that Staff B sent her a photo on at about 5:45AM, to represent how Staff B and C found Resident #10 that morning (photographic evidence obtained). She stated that she required her staff to document resident-related events with photographs and this was the reason why staff B took and sent her this photo.	A 030		

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A 030	Continued From page 29 In an interview with the Administrator on at 3:40PM, she stated that the facility did not have any -specific policies and procedures for the staff to follow. Review of the photographic evidence emailed by the facility to the AHCA surveyor on at 4:32 PM shows that Resident #10 was found by staff B and C wedged on the side bed rail with her lower extremities on the bed against the bed rail and her torso flexed at the . . . with her . . . on the floor. Review of this photo indicated that the resident's right upper extremity was beside her torso and left upper extremity was flexed at approximately 90 degrees touching the floor. Further review of this photo indicated that there were dark red stains on the bed and pillow, the nightstand lower drawer was partially opened and the cookies were inside their container on the floor next to the resident's (Photographic evidence obtained). In an interview with Staff C on at 4:45pm, she stated that on at approximately 5:45AM, she and Staff B, first moved resident #10 from the floor . . . onto the bed and then realized that they needed to stage the resident's body . . . into position so to take a photograph to represent how they initially found the resident. She stated, she and Staff B, then moved the resident's body . . . onto the floor to take a photograph. She stated that after Staff B took the photo, they both moved the resident's body . . . onto the bed again, and the administrator arrived to the facility shortly thereafter. She stated that the . . . on the bed and pillowcase was from them initially moving the body onto the bed before taking that photo. She stated that she was aware that resident #10 liked	A 030			

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A 030	Continued From page 30 to snack on cookies throughout the day and that the cookies were kept inside the resident's nightstand so she could eat the cookies in the night on her own. She stated that resident #10's family member provided her with those cookies. In an interview with the Medical Examiner Investigator on at 1:10PM, he stated that based on the evidence gathered at the facility on , resident #10 was found wedged on the side bed rail and this likely hampered her breathing which led to her . He stated that this was exacerbated due to her compromising diagnoses of and . He stated that the resident was suspected to have on due to positional asphyxia. He stated that the resident's body is in process of undergoing toxicological and histological examinations through the medical examiner's office. Class I	A 030		