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
	AL11969463	A. BUILDING: _____ B. WING _____	10/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOURLIFE OF PALM BEACH GARDENS	13465 PASTEUR BLVD PALM BEACH GARDENS, FL 33418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced licensure Complaint (#2021013821) survey was conducted on , and at Yourlife Of Palm Beach Gardens. The facility had deficiencies at the time of the 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 supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 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 observations, interviews and record reviews, it was determined that the facility failed to ensure residents are adequately supervised while sitting outside on the Memory Care Patio Areas of the facility, for 1 of 3 sampled residents. As evidence of Resident #1 being left unsupervised outside on the patio area for an extended period of time; resulting in the resident being transferred to the hospital and suffering from a heat . The findings included: Review of the facility's website on ,	A 025		

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A 025	Continued From page 2 https://www.yourlifesl.com/sites/default/files/2021-01/YLPBG-002_MCInsertBooklet_pgs.pdf, revealed that the facility advertises the following for Memory Care Services: a. Under Community Amenities, the facility lists "alarmed interior and exterior doors". b. Under Wellness . . . . . , the facility lists "State-of-the-art Wellness . . provide keyless entry into suites, enhancing security without any worries about keys, fobs or codes. The also tracks steps, alert staff to potential . . , monitor skin temperature, and can be used to call for assistance. Review of the facility policy entitled, Supervision And Monitoring Of Residents (issue date of and revised on . . . . .) notes the following: "Supervision and monitoring of residents will be done by associates as dictated by the service plan. Associates will be available in sufficient numbers with adequate training to ensure the wellness of residents while honoring resident rights and preferences. 1. Residents will be assessed prior to move in and a temporary care plan will be implemented upon admission. 2. Residents will be supervised to various degrees as identified in their assessment. 3. Supervision may include, but is not limited to supervision of activities of daily living, medications, assuring residents rights are met, participation in programs, meal intake, and overall level of functioning. 4. If there are significant changes in a resident's physical, emotional or mental functioning, the service plan will be updated to reflect these changes as they occur. 5. As a result of the service plan, appropriate	A 025		

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A 025	Continued From page 3 supervision and monitoring of residents will occur. An Adverse Incident Report filed by the facility notes that on , Resident #1 walked outside on to the covered porch, and then in to the outdoor courtyard within the secured Memory Care Unit. The resident was found by Staff A in the secured unit's outdoor courtyard seated on a bench, and unresponsive at 3:10 PM. The resident was sent by ambulance to the hospital and had expired at a hospice facility on . Resident #1's representative was interviewed on at 10:30 AM. She stated she was with the resident at the facility until 12:00 PM on , and that was the last time she saw him. Staff D (Licensed Practical Nurse/LPN), who worked during the 7:00 AM to 3:00 PM shift, stated during interview on at 12:00 PM that she observed the resident eating lunch between 12:00 PM and 1:00 PM on . Staff D stated that the two doors in the secured unit used by residents to go outside on to the covered screened patios on the bottom floor are not locked or alarmed. Additionally, the screened patio doors used to exit to the uncovered courtyard area are not locked or alarmed. She stated this resident often walked outside in the courtyard and sat on a west side bench. She identified the bench that the resident often sat on. She explained that the "willow bracelet" was used for residents to call for assistance and that Resident #1 would not wear one as he was resistant to care. Observation of the bench identified as the resident's usual sitting area was made on at 12:20 PM. The west side bench was	A 025		

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A 025	Continued From page 4 uncovered and in direct sunlight at this time (photographic evidence obtained). During observation of the exit doors to the outside courtyard area in the secured unit, both the building exit doors and screened patio doors were unlocked with no alarms. The facility staff were able to see through the glass windows from the living room and dining area into the courtyard. However, the bushes near the west side bench were approximately and obstructed the view of a person seated on the bench at this time. The documented weather on localconditions.com website shows that the temperature in Palm Beach County where this facility is located at 12:00 PM on was 87.8 degrees, and 89.6 degrees at 3:10 PM. Staff A (Personal Care /PCS) was assigned to provide personal care for the resident on during the 7:00 AM to 3:00 PM shift, and also on the 3:00 PM to 11:00 PM shift (double shift). Staff A was the first staff member who found the resident and unresponsive on . Staff A stated during interview on at 11:55 AM this was her "second day working at the facility", and that there were no routine required checks for residents in the secured unit. She had gone outside to check on the resident for no stated reason. Staff B (LPN), who worked the 3:00 PM to 11:00 PM shift, stated during interview on at 12:10 PM, that it was usual for the resident (Resident #1) to walk outside on to the covered porch area unaccompanied and unsupervised as the doors were not locked or alarmed. She stated she took the resident's temperature before he was transferred to the hospital on and that it was "104 something".	A 025		

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A 025	Continued From page 5 Staff C (PCS) stated during interview on at 5:00 PM that she saw the resident last on "around 1:00 PM going on to the patio". The facility's Initial Assessment of Resident #1 dated notes that the resident is "occasionally forgetful to time and place" and that "he will need to utilize the Blue Willow system". The "willow bracelet" was used by some residents to call for assistance, and to monitor a resident's location. Resident #1's service plan printed on documents that the resident has "frequent disorientation and ," and that he is to receive "Blue Willow" services "every day; AM, PM, NOC (night time)". The Three Tiered Memory Care Assessment has "wellness checks Q (every) 2 to 4 times daily" circled as a service for the resident. There are no scheduled times for resident checks or documentation available to show routine observations of the resident during mealtimes or care. There was no documentation in the assessments or service plan to indicate the resident's desire to walk outside and any interventions needed to prevent the resident from heat related injury. The resident's most recent Health Assessment (AHCA Form 1823) dated notes the resident has a diagnosis of " ( )" and is "alert w/ (with) ". The Progress Notes in Resident #1's file show that he moved in to the facility on , and was documented as "a and exit seeker, willow bracelet assigned". The notes indicate that on at 4:03 PM, the resident was "found outside by PCS and oncoming nurse , and unresponsive. Writer tried to arouse patient with rub but still no response. 911 was called ...". The "Vitals" log (temperature,	A 025		

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A 025	Continued From page 6 pressure, , ,) has a temperature of 104.6 degrees noted at 4:02 PM on for this resident. Review of the 911 transcripts obtained from local law enforcement show the facility called for emergency assistance at 3:44 PM on . The 911 audio file has Staff B requesting emergency services, stating that the resident "was sitting on the bench out in the heat too long and we can't arouse him...probably , ". The Fire Rescue report notes that the resident was assessed by EMTs (Emergency Medical Technicians) at 3:55 PM on for a heat related emergency. Review of the hospital records shows that Resident #1 was admitted to the hospital on and was diagnosed and treated for "heat " with an axillary temperature of 104 degrees upon admission. The record shows he was treated and then discharged to a hospice facility on where he expired on . During interview with a representative from the Medical Examiner's Office on at 12:37 PM, she stated that the resident's cause of was "complications from Hyperthermia". During interview with the Administrator on at 6:18 PM, she acknowledged these findings. The facility provided no additional information for review at this time. Class II	A 025		
A 165	429.23(&) FS Risk Mgmt & QA	A 165		

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A 165	Continued From page 7 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a	A 165		

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A 165	Continued From page 8	A 165		

preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.
(4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.
(6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415.
(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.
(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report

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A 165	Continued From page 9 this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to file an Adverse Incident Report within one (1) business day of the occurrence for 1 of 3 sampled residents (Resident #1). The findings included: An Adverse Incident Report filed by the facility on notes that on , Resident #1 was found in the secured Memory Care Unit's outdoor courtyard seated on a bench, and unresponsive at 3:10 PM. The resident was sent by ambulance to the hospital and had expired at a hospice facility on . 911 transcripts obtained from local law enforcement show the facility called for emergency assistance at 3:44 PM on . The 911 audio file has Staff B (Licensed Practical Nurse/LPN) requesting emergency services, stating that the resident "was sitting on the bench out in the heat too long and we can't arouse him...probably ". The Fire Rescue report notes that the resident was assessed by EMTs (Emergency Medical Technicians) at 3:55 PM on for a heat related emergency.	A 165		

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A 165	Continued From page 10 Review of the hospital records shows that Resident #1 was admitted to the hospital on . . . . . and was diagnosed and treated for "heat ". The record shows he was treated and then discharged to a hospice facility on where he expired on . During interview with a representative from the Medical Examiner's Office on . . . . . at 12:37 PM, she stated that the resident's cause of was "complications from Hyperthermia". The facility failed to file an Adverse Incident Report within one (1) business day of the occurrence on . . . . . for this resident's condition that required the transfer of the resident to a unit providing more acute care due to the incident rather than the resident's condition before the incident. Class III	A 165		