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
	AL11969632	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBEY DELRAY ASSISTED LIVING AND MEMORY CA	2010 SW 11TH COURT 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 000	Initial Comments An unannounced Relicensure with Extended Congregate Care (ECC), Complaint (#2022005105) and Generator Monitoring survey was conducted on and at Abbey Delray Assisted Living and Memory Care. The facility had deficiencies related to the Relicensure with Extended Congregate Care (ECC) at the time of the survey.	A 000		
A 090	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interviews, 2 of 3 sampled employees' records reviewed (Employee B & C) did not complete the training on ( ). The findings included: 1) Review of the employees' records on revealed that two employees did not complete the training. Employee B was	A 090		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969632	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBEY DELRAY ASSISTED LIVING AND MEMORY CA	2010 SW 11TH COURT 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 090	Continued From page 1 hired on . . . . . as a certified nursing assistant. The staffing schedule reveals that she works a fluctuating week day/weekend schedule from 7:00 AM to 3:00 PM. Employee B confirmed during an interview with her, on . . . . . at 10:59 AM, that she works at the facility as indicated. However, Employee B was not sure what . . order implied. 2) Employee C personnel file was reviewed and there was also no evidence of the completion of the . . . . policy and procedures training. The record showed Employee C was hired on . . . . . and works the night shift 11:00 PM to 7:00 AM. During an interview with Employee C on . . . . . at 2:30 PM, she confirmed that she works at the facility as indicated on the schedule. At the Exit meeting on , no evidence was provided to indicate that Employee B and C had completed the training. Class	A 090		
AE210	59A-36.011(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING. (a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted	AE210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969632	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBEY DELRAY ASSISTED LIVING AND MEMORY CA	2010 SW 11TH COURT 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
AE210	Continued From page 2 living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to , shall not be required to take the assisted living facility core training competency test. (b) The administrator and the ECC supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, , or social needs of frail elderly and persons, or persons with 's or related . (c) All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility. This Statute or Rule is not met as evidenced by: Based on record review and interviews, 2 of 3 sampled employees (Employee B & C) did not complete the extended Congregate Care (ECC) training. The findings included: Review of the employees' records on revealed that two employees did not complete the ECC training. Employee B was hired on as a certified nursing assistant (CNA). The staffing schedule revealed that she worked a fluctuating week day/weekend schedule from 7:00 AM to 3:00 PM. Employee B confirmed during an interview with	AE210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969632	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBEY DELRAY ASSISTED LIVING AND MEMORY CA	2010 SW 11TH COURT 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
AE210	Continued From page 3 her, on . . . . . at 10:59 AM, that she works at the facility as indicated. 2) Employee C personnel file was reviewed and there was also no evidence of the completion of the ECC training. The record showed Employee C was hired on . . . . . and worked the night shift 11:00 PM to 7:00 AM. During an interview with Employee C on . . . . . at 2:30 PM, she confirmed that she works at the facility as indicated on the schedule. At the Exit meeting on , no evidence was provided to indicate that Employee B and C had completed the ECC training. Class III	AE210		

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
	AL11969632	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBEY DELRAY ASSISTED LIVING AND MEMORY CA	2010 SW 11TH COURT 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
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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
	AL11969632	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBEY DELRAY ASSISTED LIVING AND MEMORY CA	2010 SW 11TH COURT 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
CZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	CZ830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969632	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBEY DELRAY ASSISTED LIVING AND MEMORY CA	2010 SW 11TH COURT 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
CZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on Record Review, Interview and observation, the facility failed to timely submit/or obtain approval of their Comprehensive Emergency Management Plan (CEMP). The Findings Include: During the Re-Licensure Survey conducted at the facility on [redacted] and [redacted] a request was made to the Administrator for the facility's Comprehensive Emergency Management Plan (CEMP) approval letter. In an interview with the Administrator and Interim Health Care Coordinator on [redacted] at 2:46 PM, the Interim Health Care Coordinator provided this Surveyor a folder containing the facility's CEMP letter dated [redacted]. During review of the letter this Surveyor observed "Expired Plan Notification" annotated on the letter informing the facility the approval has been expired for over six (6) months. During the interview the Interim Health Care Coordinator stated the previous Administrator submitted it several times, and there was one piece missing, which has been submitted. He also stated he spoke with the representative at the Local Emergency Management Division who stated he has it but hasn't approved it yet. In an interview with the Interim Health Care Coordinator on [redacted] at 3:09 PM the Interim Health he stated he spoke with the representative	CZ830		

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
	AL11969632	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBEY DELRAY ASSISTED LIVING AND MEMORY CA	2010 SW 11TH COURT 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
CZ830	Continued From page 3 at the Local Emergency Management Division who informed him the request was not there yet and gave me the facility's CEMP letter. A review of the letter dated . . , revealed it was the previous letter provided entitled "Expired Plan Notification" On the Survey Team met with the Administrator, Interim Health Care Coordinator, Nurse Care Coordinator, and Regional Director to conduct the Exit Conference. The were informed of the findings to which they acknowledged. Class III	CZ830		