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
	AL11969052	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DISCOVERY VILLAGE AT PALM BEACH GARDENS	100 DISCOVERY WAY 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 Relicensure, Complaint (#2022017027) and Generator Monitoring survey was conducted on through at Discovery Village at Palm Beach Gardens. The facility had deficiencies identified related to the Relicensure at the time of the survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is	A 010		

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A 010	Continued From page 1 agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must	A 010		

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A 010	Continued From page 2 notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner,	A 010		

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A 010	Continued From page 3 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A . , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.	A 010		

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A 010	Continued From page 4 (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. 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 a resident met the criteria for continued residency, for 3 out 4 residents' records reviewed (Resident #15, #14 and #11). The facility failed to ensure that a resident was reassessed by his/her primary care physician when the resident exhibited significant health changes and the findings documented on a new Resident Health Assessment form (AHCA form 1823) to determine if the facility could meet the care needs of the resident. The findings included: a) Review of the census sheet provided by the Acting Administrator and Staff B (LPN) at 8 AM on revealed that Resident #15 was receiving hospice services. During an interview with the Regional Director and Maintenance Director on at 10:42 AM, prior to entering Resident #15's room, it was revealed the resident had Private Duty Aide (PDA). During observations of Resident #15 on at 10:44AM with the Regional Director and the Maintenance Director, the resident (small in stature and fatigued), was observed bedbound, in a hospital bed, and in her room. The resident was observed in the room alone. At this time, the Maintenance Director stated the resident was partially but could speak and that I needed to get closer so she could see and hear me. The resident was asked if she had breakfast yet, she	A 010		

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A 010	Continued From page 5 stated "No". The Regional Director was questioned regarding the whereabouts of the PDA and why she was not in the room. The Regional Director was also questioned regarding the facility staff checking on the resident and providing ADL care. The PDA was finally located, and she entered Resident #15's room around 10:55 AM on . She stated she was going to get breakfast from the kitchen for the resident because she had just awakened and had not had breakfast. She was questioned regarding her shift with Resident #15, she stated her time varies depending on her , , , but usually her hours are from 11am to 7pm. She stated she assists the resident with care and gives her medications daily which are stored in the resident's room. During an interview with the Regional Director on at 11 AM, Resident #15's care was discussed and the hours the PDA is present for the resident. She was requested to provide proof of the person(s) and times the resident was assisted with care and monitoring for the prior day and any other days of the current week. She stated the Director of Nursing would be able to provide that information and that she was on the way. During confidential staff interviews on at 11:15 PM, it was determined that Resident #15's private duty aid comes and goes at various times. It was further revealed that they are not sure of the exact schedule, but we can confirm she has a PDA. Review of Resident #15's Resident Health Assessment (AHCA form 1823) dated documented diagnoses of Dyslipidemia, , (,), Hyponatremia, , , .	A 010		

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A 010	Continued From page 6 and . . . Physical and sensory limitations listed as assist with transfer. Nursing/treatment/ service requirements noted as none. Resident #15's activities of daily living noted as total except for eating which is listed as independent. Further review of the form revealed the resident requires assistance with self-administration of medications. During an interview with Resident #15's private duty aid on . . . . . , she stated she arrived early today. She was asked if the resident had eaten today, she stated "No". She stated the resident doesn't really eat. She stated, she has lunch for the day; she pointed to a turkey sandwich with lettuce and tomatoes. She was asked, could the resident eat this meal, she stated, "No". She stated she would have to break it up into small pieces and maybe the resident will eat it. She stated, the resident does better with softer meals. Further observations of Resident #15's bedroom revealed her bed was pushed against the left wall (near the window). A call light/bell system with a pull cord was observed on the middle wall (located in the middle of the wall). However, it was not accessible for the resident, the cord was (See photographic evidence). Therefore, the resident could not call for assistance. During an interview with the Director of Health and Wellness (Staff M) on at 1 PM, the resident's condition, care needs, and the private duty aid task/hours were discussed. She was unable to provide documentation and/or evidence reflecting that the facility staff was monitoring and/or assisting the resident during the hours the private aid was not present. The DON was questioned regarding the additional residents that had a private duty aid. She further stated she was	A 010		

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A 010	Continued From page 7	A 010		

unable to identify all residents in the building who had a private duty aid and/or the hours. She stated, they are to sign in upon arrival however, they were not all following the protocol. She also confirmed Resident #15's private duty aid was not signing in.

Additional review of Resident #15's file revealed she had not been reassessed for continued residency to ensure that the facility was capable of meeting her care needs and coordinating her needs appropriately (including 3rd party services).

b) During observations of Resident #14 in the Memory Care Unit (MCU) dining room at approximately 8:10 AM, she was observed yelling and screaming in a continuous manner while sitting in her wheelchair at the table awaiting breakfast. Staff N (LPN) stated during an interview at 8:25 AM on , that Resident #14 is fine and in no , , she does this all the time. The screaming continued until the Wellness Director (Staff C) removed her from the dining area to the patio area. Resident #14 was observed again during the lunch meal at approximately 11:45 AM on in the MCU, yelling and screaming again. She was observed with her lunch meal that consisted of a large hotdog in a . . with ketchup on top. At this time, the Wellness Director was questioned whether the meal was appropriate for the resident to consume due to her condition. She stated, "yes, she will chew the hotdog and consume the juices and then spit it out". She further stated, the resident can feed herself with assistance.

Record review of Resident #14's file revealed an admission date of . Resident 14's Health Assessment form (AHCA form 1823) dated completed by the physical revealed

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A 010	Continued From page 8 diagnoses of [redacted] status noted as [redacted]. Further review of the form revealed the resident only requires assistance with her Activities of Daily Living (ADLs). The form documents resident diet instructions as a mechanical soft. Resident is also noted as requiring 24-hour nursing or [redacted] care and that the individual's needs couldn't be met in an Assisted Living Facility. In addition, the AHCA form 1823 medical certification section was incomplete: missing medical license number, telephone number and address of the examiner. During an interview on [redacted] at 2:27 PM with the Director of Health and Wellness (Staff M) and Director of the MCU (Staff C), both acknowledged the findings and the inaccurate AHCA form for Resident #14, including her ADLs noted incorrectly on the form and her decline in condition. c) On [redacted] during an observation at breakfast time between 8:00 AM and 8:40 AM in the Memory Care Unit, Resident #11 was observed in the dining area in a highbacked wheelchair at the dining table. Resident #11 was observed to have a Private Duty Aide (PDA) seated directly next to him providing total care to the resident. Resident#11 was observed being fed by his PDA breakfast at 8:30 AM. Resident #11 was observed motionless and unable to assist with any of his ADLs. Record of Resident #11's file revealed an admission date of [redacted] to the facility. Review of Resident #11's Health Assessment form (AHCA form 1823) dated [redacted] documented diagnoses PD ([redacted]'s [redacted]), hx of DBS (deep [redacted] stimulation. Physical or sensory	A 010		

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A 010	Continued From page 9 limitations documented as gait limited due to [illegible] or behavior status noted as mild [illegible] issues. Further review of the form documents that the resident requires assistance with all ADLS except [illegible] which is noted as requiring supervision. Further review of Resident #11's file lacked documentation indicating resident was receiving hospice services. During an interview with the Director of Wellness and Director of MCU on [illegible] at 2:35 PM, it was revealed that Resident #11 requires total care with all ADLs and that the resident is not currently enrolled in hospice services. At this time, the surveyor discussed with the parties that all residents admitted to an Assisted Living Facility must be able to perform ADLs with assistance or supervision. And that Resident #11 didn't meet those criteria. Class III	A 010		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility	A 152		

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A 152	Continued From page 10 supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [illegible] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [illegible] or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be [illegible]. This Statute or Rule is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to maintain the Memory Care Unit in a safe manner, free from hazards. In addition, the facility failed to ensure that all electrical and appurtenances were maintained in good working order. The findings included: During a tour of the facility's memory unit on [illegible] at approximately 8:10 AM, the following concerns were noted.	A 152		

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A 152	Continued From page 11 1) The entire dining room floors in the Memory Care unit were sticky and dirty. As the surveyors walked the area, you could feel and hear the stickiness. 2) 2 staff members were observed plating meals and serving residents from the enclosed prep area located in the middle of the dining room. Further observations of this area revealed multiple food steam units and other various cleaning items. On multiple occasions on at around 8:20 AM, staff were observed leaving the area without securing the access doors to the prep area. Multiple residents were observed walking in the area. 3) Random call lights were tested on the 1st floor and the 2nd floor of the building on and between the hours of 8 am and 1 PM at the facility with the Regional Director and the Maintenance Director. This test revealed multiple units were not signaling for assistance. Although, the call light was pulled, it was not registering to the pager system of the staff. Each staff member has an app on their phone that signals the resident's room. According to the Maintenance Director and confirmed by Staff B and the Director of Wellness, each person on the assigned floor must go and check the resident and/or inquire to the type of assistance needed. They confirmed that they had been having problems with the call system for a while and were not sure of the problem. They stated they will address the system and ensure it is up and running. Class III	A 152		