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
	AL11969725	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CAPSTONE AT ROYAL PALM	10621 OKEECHOBEE BLVD ROYAL PALM BEACH, FL 33411

(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 (#2024000009) and Generator Monitoring survey was conducted at The Capstone At Royal Palm on and . The facility had deficiencies related to the Relicensure at the time of the survey.	A 000		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not	A 078		

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
	AL11969725	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CAPSTONE AT ROYAL PALM	10621 OKEECHOBEE BLVD ROYAL PALM BEACH, FL 33411

(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 078	Continued From page 1 constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interview, The facility failed to ensure that staff submit a written statement from a health care provider documenting the individual is free from signs or	A 078		

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
	AL11969725	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CAPSTONE AT ROYAL PALM	10621 OKEECHOBEE BLVD ROYAL PALM BEACH, FL 33411

(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 078	Continued From page 2 symptoms of communicable . . . . . for 2 of 4 (Staff D, J) The findings included: A review of Staff D's employee file revealed a hire date of . . . . . as a caregiver / certified nursing assistant (CNA). Staff D's file contained no evidence of documentation of a statement from a health care provider that indicated Staff D was free from signs or symptoms of communicable . . . ( ) within 6 months prior to hire or within 30 days of hire. On review of Staff J's employee file revealed a hire date of . . . . . as a med-tech. Staff B's file contained no evidence of documentation of a statement from a health care provider that indicated Staff J was free from signs or symptoms of communicable . . . . . ( ) within 6 months prior to hire or within 30 days of hire. On . . . . . at 3:15pm in an interview with the Administrator, she stated she understands a statement from a health care provider that indicates staff is free from signs or symptoms of communicable . . . . . ( ) must be completed and documented in all staff charts. Class III	A 078		
A 089	429.178 FS /Other - Special Care 429.178 Special care for persons with	A 089		

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
	AL11969725	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CAPSTONE AT ROYAL PALM	10621 OKEECHOBEE BLVD ROYAL PALM BEACH, FL 33411

(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 089	Continued From page 3 s . . . . . or other related . . . . . .-A facility which advertises that it provides special care for persons with . . . . . ' s . . . . . or other related must meet the following standards of operation: (1)(a) If the facility has 17 or more residents, have an awake staff member on duty at all hours of the day and night; or (b) If the facility has fewer than 17 residents, have an awake staff member on duty at all hours of the day and night or have mechanisms in place to monitor and ensure the safety of the facility ' s residents. (2) Offer activities specifically designed for persons who are . . . . . . (3) Have a physical environment that provides for the safety and welfare of the facility ' s residents. (4) Employ staff who must complete the training and continuing education required under s. 430.5025. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have documentation of complete courses for . . . . . -specific training for 2 of 4 staff sampled (Staff J, K). The facility failed to employ staff who have completed the training and continuing education required. The Findings Include: On review of Staff J's personnel file revealed a hire date of . . . . . as a med-tech. Staff J's file contained no documented evidence of 4 hours of initial . . . . . -specific training within 3 months of hire and 4 additional hours of . . . . . -specific training and completed within 9 months after beginning employment.	A 089		

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
	AL11969725	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CAPSTONE AT ROYAL PALM	10621 OKEECHOBEE BLVD ROYAL PALM BEACH, FL 33411

(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 089	Continued From page 4 On . . . . . review of Staff K's personnel file revealed a hire date of as a med-tech. Staff J's file contained no documented evidence of 4 hours of initial -specific training within 3 months of hire and 4 additional hours of -specific training and completed within 9 months after beginning employment. On . . . . . at 3:15pm in an interview with the Administrator, she stated she understands . . . . . -specific training must be completed and documented in staff charts, she stated she will have Staff J and K complete the required -specific training. Class III	A 089		