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
	AL11953207	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINVIEW	145 EXECUTIVE CENTER DRIVE WEST PALM BEACH, FL 33401

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A 000	Initial Comments An unannounced Complaint survey, #2025011962 was conducted from /2025 at Fountainview. The facility had deficiencies at the time of the visit.	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 resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 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 observation, interview and record review, the facility failed to provide the level of care, services and oversight required to meet the needs of 1 of 1 sampled residents. This was evidenced by the failure to ensure the resident's physical well-being and failure to effectively implement staff communication when Resident #1 was returned to the facility after 2 separate hospitalizations, and sustained life threatening injuries. The failure places all residents at risk of harm and/or injury after hospitalization. The findings include: Resident #1 originally moved into the	A 025		

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A 025	Continued From page 2 independent living section of the facility on /20222 and later was admitted to the Assisted Living Facility (ALF) section, moving into apartment 401-A on the fourth floor of Building #5. Review of Resident #1's Advanced Practice Registered Nurse (APRN) notes dated on indicated medical diagnosis' including difficulty walking, unsteadiness on , history of repeat , right , and past of the . Resident#1 is prescribed the following medications: 200 mg ( ); Divalpropex 500 mg ( ); 40 mg ( ), 800 mg( ), 5 mg ( ); 40 mg ( ); ER 100 mg ( ); and 1MG (spasms). The visit note indicated that the "resident is being seen to establish care, initiate plan of care and management of issues. The note indicated that the resident is compliant with a care plan, adherent to medications and has no new complaints reported. The visit note indicated that Resident#1 has had frequent and has an old . The family is requesting a wheelchair to improve mobility and safety. Home health services , and , are ordered in effort to delay functional decline." Review of Resident #1's facility electronic nursing progress notes dated on 8:02 AM indicated Resident#1 was found in his room at 6:41 AM, from the right . Resident #1 stated he was getting up too fast and . The	A 025		

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A 025	Continued From page 3 resident was sent 911 to the hospital for evaluation. On at 12:21 PM. Resident#1 is returned to facility with no new orders, but with 4 on his right , and a dry noted on the right . The APRN was notified of the need for care. Review of Resident #1's Health Assessment form 1823 dated on indicated the resident medical diagnosis' including , , , , , and , . The form indicated Resident#1 was alert, oriented and independent for activities of daily living (ADL) but required supervision for . The form indicated that Resident#1 ambulates with a walker and was assessed as a risk. Further review of the form indicated that the resident required a nurse to provide care to a on the right , . Resident #1 also required assistance with self-administration of medication. Review of Resident #1's APRN notes dated indicated that Resident #1 had a with a , and was seen in the hospital, received . The visit note indicates that Resident#1 is alert and oriented at baseline which is ongoing, no reported decline and the family is involved and periodically updated. Resident#1 is assessed to be active with other residents, with a calm . No new injuries or were noted. Resident#1 needs minor assistance with ADLs and continues to be at risk for . Review of Resident #1's facility electronic nursing progress notes dated 16:42 indicated that the resident stated he in his living room a few days ago and was complaining of lower , . The nurse observes the resident's to be pinkish in color.	A 025		

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A 025	Continued From page 4 Review of Resident #1's APRN notes dated indicated that Resident had a with on the and continues to be at risk for . Resident #1 is assessed as alert and oriented at baseline which is ongoing, no reported decline and the family is involved and periodically updated. The Resident is active with other residents, calm, diet fair, with no new injury or . Resident #1 continues to need minor assistance with ADLs and continues to be at risk for . Review of Resident #1's APRN notes dated indicated the resident was complaining of abnormal movements and would like to see for possible colonoscopy. Resident #1 is assessed as alert and oriented at baseline which is ongoing, no reported decline and the family is involved and periodically updated. The Resident#1 is active with other residents, calm, diet fair, with no new injury or . Resident#1 continues to need minor assistance with ADLs and continues to be at risk for . The note indicates a referral is sent to the for evaluation. Review of Resident #1's facility electronic nursing progress notes dated after indicated no nursing note regarding a referral. In an interview with the corporate regional nurse on at approximately 10 AM when questioned about the APRN note with a referral, she stated she could find no written referral by the APRN. She stated that since there was no facility progress note indicating a referral, there was no referral received. She stated that she assumed that the	A 025		

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A 025	Continued From page 5	A 025		

facility was never made aware of the referral since the nurse would have responded to the order. She stated that the APRN did not indicate any follow-up documentation in the visit note on . She stated that during that time, facility access to the visit notes and communication was poor.

Review of Resident #1's APRN notes dated indicated that the resident is assessed as alert and oriented at baseline, which is ongoing, no reported decline and the family is involved and periodically updated. The Resident is active with other residents, calm, diet fair, with no new injury or . Resident#1 continues to need minor assistance with ADLs and continues to be at risk for . Further review of the visit note indicates there is no mention of any referral or follow-up.

Review of Resident #1's APRN notes dated indicated that the resident is assessed as alert and oriented at baseline which is ongoing, no reported decline and the family is involved and periodically updated. The Resident is active with other residents, calm, diet fair, with no new injury or . Resident#1 continues to need minor assistance with ADLs and continues to be at risk for . Further review of the visit note indicates there is no mention of any referral or follow-up.

Review of Resident #1 Level of Care Plan dated indicated that the resident could make decisions independently, was consistent, and reasonable. He was and . Resident #1 could ambulate independently and may use a walker or wheelchair. Resident#1

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was identified as having a high risk for . He was independent for bathing and , requiring no assistance. He requires assistance with medications. His level is assessed as level two, no unmanageable . He was assessed to be safe to leave the community without an escort. Requirement for Service Plan , , the resident needs assistance arranging medical , , , requesting staff to call, to schedule and accompany him , , .

In a phone interview with Care Staff #A on at 2:28 PM she stated she was very familiar with Resident#1, she stated he was independent with ambulation but required a walker. She stated that Resident#1 would ambulate to the Independent Living dining room across campus to take his meals. She stated Resident#1 didn't believe he needed supervision with ambulation. She stated Resident#1 had balance issues, but he had not had any . She stated she assisted him with showers, and he also needed assistance with his medications.

Review of Resident #1's Health Assessment form 1823 dated was not updated to reflect the current ADL care needs that were being provided to the resident.

Review of Resident #1's APRN notes dated indicated that the resident is assessed as alert and oriented at baseline which is ongoing, no reported decline and the family is involved and periodically updated. The Resident is active with other residents, calm, diet fair, with no new injury or . Resident#1 continues to need minor assistance with ADLs and continues to be at risk for . Further review of the visit note indicates there is no

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A 025	Continued From page 7 mention of any ˘ referral or follow-up. Review of Resident #1's facility electronic nursing progress notes dated prior to indicated no explanation of the resident's transfer to the hospital. Further review of Resident #1's facility electronic nursing progress notes dated at 8:30 indicated that the resident returned from the hospital. A skin assessment was completed with no abnormalities noted. Review of Resident #1's facility electronic nursing progress notes dated 7:31 indicated that the resident returned from the hospital and was alert oriented and capable of verbalizing needs. There were no open areas noted. The nurse documents that Resident #1 could ambulate with a walker, without changes in mobility observed and he denied any / discomfort. Review of Resident #1's APRN notes dated indicated that the resident is hospitalized for a . The resident is assessed to be alert and oriented at baseline, which is ongoing, no reported decline and family is involved and periodically updated. He is active with other residents, calm, diet fair, has no new injury or . Resident#1 continues to need minor assistance with ADLs and continues to be at risk for . There is no mention of a ˘ referral or follow-up. The note includes an assessment plan: Difficulty walking- / (/) evaluation to assess adaptive equipment, fine motor coordination, ADL independence, proper body mechanics, gait, balance, transfers, functional abilities, and home safety. Needs assessment for therapeutic exercises, ADL re-education, safety education, and transfer	A 025		

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A 025	Continued From page 8 training. Review of Resident #1's electronic nursing progress notes dated after indicated no nursing note regarding a / evaluation or referral. Review of Resident #1's APRN notes dated indicated that the resident reports lower , with . He stated he feels weak and is transported to hospital for evaluation. Review of Resident #1's facility electronic nursing progress notes 16:41 indicated that the resident is seen by the APRN who gave a verbal order to transfer the resident to the hospital for evaluation of , and . Resident#1 is able to voice concerns to 911 personnel. The resident's room keys and cell phone were locked in the apartment by facility management. Review of Resident #1's facility electronic nursing progress notes 12:03 indicated that the Administrator received a phone call from the facility's Culinary Director, who was covering weekend management duty, notifying her that Resident#1 had returned to the facility. Resident#1 had ambulated to the Welcome Center, across the campus, after attempting to get into his apartment. Further review of the note indicated that Resident#1 informed her that the hospital transportation brought him to the ALF and he went to his apartment then walked to the Welcome Center. Resident#1 informed the Administrator that he was not feeling well, insisting that he wanted to go to the hospital. The Administrator instructed Resident#1 to remain at the Welcome Center and called the	A 025		

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A 025	Continued From page 9 nurse on duty to come and get him. The note further indicated that the Administrator instructed the nurse to send Resident#1 transported to the hospital. In an interview with the Culinary Director on at 9:50 AM she stated Resident#1 would routinely eat his meals in the Independent Living dining room with friends who he had met while living in that section. She stated Resident#1 was always cheerful, very friendly, and attended activities. She stated Resident#1 never express any thoughts and she was in about his . She stated that on around 12 PM, she was covering facility weekend management responsibilities, when she got a call from the Welcome Center staff that Resident#1 was there and "didn't look well, he was complaining of , ". She stated that she observed Resident#1 to be "pale, looked tired, he was complaining of feeling , and was holding his ". She stated she called the Administrator and the nurse to come to assess the resident. She stated Resident#1 was sent out 911 to the hospital for evaluation. Review of facility records for the Culinary Director revealed she was not appropriately trained to perform supervisory or management duties for the ALF residents residing in the facility. The facility had not provided any training to prepare her to effectively take on the supervisory role on the weekend to ensure the safety and well-being of the residents. Review of Resident #1's facility electronic nursing progress notes 12:20 PM indicated that Resident#1 had returned from the hospital and the nurse was notified the resident was not feeling well and needed to return to hospital. The	A 025		

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A 025	Continued From page 10 nurse documents that Resident#1 was observed sitting on a couch in the Welcome Center, he stated he had had a colonoscopy done that day and for "some reason I don't feel right". The nurse transports Resident#1 to the Assisted Living Facility nurses' station in building 5 and his vital signs were taken, - P 94. The nurse calls 911 to transfer Resident#1 to the hospital. The note indicates that the nurse did not receive any hospital discharge paperwork from the resident. In an interview on at 11:35 AM with the nurse on duty on , she stated that Resident#1 was transported to the facility around 12 PM on . She was unaware of his return until she received call on radio from the Welcome Center that Resident#1 was not feeling well. She stated she brought a wheelchair to the Welcome Center and wheeled him to the nurses' station in Building 5. She stated she took his vital signs which were stable. She stated that Resident#1 was complaining of , and that he "couldn't feel his mid-section". She stated that she called 911 and the resident was transferred to the hospital. She stated that around 5 PM, she received a call on her radio to "Call 911- there is an emergency". She stated she was unaware what was happening but called 911 and went down to the nurses' station. As she was getting off the elevator, she was directed by staff to go outside of the front door of building #5. She stated she saw a male resident on the ground from his , she stated that when she realized it was Resident#1, her sank. She stated she applied pressure to Resident #1's , "there was a lot of ". She stated Resident #1 was and he stated, "he jumped from his 4th floor balcony". She asked him why and he stated that "he didn't want to live	A 025		

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anymore". When 911 arrived, she stated that she called the resident's son to inform him of the situation and to go immediately to the hospital. She stated that she had not been notified by the hospital that Resident#1 was returning after the 2nd discharge. She stated that she was unaware that Resident#1 had been brought to the facility.

Review of Resident #1's facility electronic nursing progress notes 18:48 indicated that the nurse received call by radio from a caregiver to call 911. The nurse documents she was unaware of the incident or any specifics when receiving this call. The note indicates she goes to the 1st floor and is directed to walk outside of building 5. She observed Resident#1 lying on his right side on the ground and observed coming from the right side of the . The note indicated she was applying pressure to the resident's to stop the . The nurse questions Resident#1 about what happened, and he tells her "he jumped from the fourth floor, and he didn't want to live anymore". Further review of the note indicated that the nurse was informed that the hospital transportation driver had brought the resident to his room in the facility and noticed the resident on the ground as he was exiting the building. The nurse documents that she not aware that Resident#1 had been discharged from the hospital a second time and that he had been brought to the facility.

In a phone interview with Care Staff #A on at 2:28 PM she stated she routinely works the weekend and on she worked two shifts, 7am- 3p and 3p-11p. She stated that normally there are five care staff on duty per shift, which includes one assigned to assist residents with medications. She stated that there was one

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nurse assigned to buildings 4 and 5. She stated that on that day, , there was a staff call off, so there were four care staff on duty to cover both buildings. She stated that she recalled that late in the morning on , she was called on the radio that Resident#1 was trying to get into his room, Building 5, . She stated she did not see him return. She stated she spoke with the resident, who told her he had arrived with the hospital transport driver. She stated that Resident #1 was complaining about his abdomen hurting and she asked him if he had seen the nurse. He told her yes; he had seen the nurse. She stated that she was informed Resident#1 was sent out 911 for "not feeling well". She stated that around 5 PM, as she was wheeling another resident to the dining room in building 5, a family member of another resident alerted her that there was a resident lying on the grass outside of building 5. She stated that she ran outside and saw Resident#1, on the ground directly below his 4th floor room, his ⌄ were broken, and he was ⌄ from his . She yelled for a towel to control the ⌄ and notified the nurse to call 911.

Review of Resident #1's facility electronic nursing progress notes 9:13 indicated that the facility nurse spoke with a hospital nurse informing her that Resident #1 had sustained injuries including , and and . The resident was placed on a .

Review of Resident #1's hospital discharge paperwork from the second admission on , indicates an evaluation for , and , , , and is dated at 16:43. A follow-up referral with an Internal Medicine physician is recommended and additional

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A 025	Continued From page 13 documents are noted given to the patient included Discharge Plan, Home Medications list, and Emergency Department Personal Safety Plan. The paperwork indicates the following medications: 20mg daily- last taken unknown- Divalprox 500mg delayed release converted - last taken unknown- Halperidol 5mg -last taken unknown- Lacoamide 200mg -last taken unknown - Lamotriqine 150mg daily- last taken unknown- In a phone interview with Resident #1's APRN on she stated Resident #1 had been her patient for years. She stated he was living in the independent living section until he started to experience increasing and the resident's family thought it would be safer for him in the more structured setting, Assisted Living Facility (ALF) section. Resident#1 moved into the ALF since family believed he couldn't be left alone. She stated that the Resident#1 was agreeable to the transfer. She stated that she did not assess the resident as becoming more depressed. The APRN stated she suggested that Resident#1 use a rolling walker for support during ambulation, and he used a high standing walker. She stated Resident#1 would ambulate from building 5 to the independent section across campus for his meals. She stated that she saw him last for his complaint of , and he was transferred to the hospital for evaluation. When the surveyor questioned the APRN regarding her note dated which indicated Resident#1 was complaining about abnormal movements and his request to see a	A 025		

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	AL11953207	A. BUILDING: _____ B. WING _____	08/25/2025

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A 025	Continued From page 14 , she stated she made a referral but believed Resident#1 never followed up with the , , . Review of the APRN visit note on does not indicate a follow-up discussion with Resident#1 about the referral. When questioned, she stated that Resident#1 "didn't go". She stated she had no explanation about what may have triggered Resident#1 to jump from his room balcony. When asked if the hospitalization or a change in medication schedule could have been a contributing factor, she stated that she didn't believe so. She stated that Resident#1 had recently had a and was transferred to the hospital for evaluation with no change in treatment implemented. In an interview with the Administrator on at 9:35 she stated that she had been notified of the incident on involving Resident #1. She stated that the facility investigated the event. The Administrator was questioned about the facility's policy when a resident is discharged from the hospital and returns to the ALF. She stated that the hospital should call with a report, but that does not routinely happen. She stated that during her investigation it was determined that Resident #1's second discharge occurred around 4:41 PM, since review of the discharge paperwork indicated a discharge time of 4:41PM. The Administrator stated that a hospital transport company wheeled Resident #1 directly to his room. The transport person left the resident and went down the elevator. As he exited the building, he observed a resident lying on the ground. The transport person went inside to call for help. She stated that staff on duty responded, and the nurse was called by radio. The Administrator was asked if Resident #1's balcony was secured; she	A 025		

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A 025	Continued From page 15 stated that residents could access their balcony for fresh air. The Administrator stated that she and the Assistant Director met with hospital case management to discuss the breakdown in communication regarding Resident#1's discharge. She stated she made a request that the hospital staff call the ALF to inform when a resident is discharged. Review of an email confirmation of the meeting was provided by the Administrator for review which revealed that "Resident #1 was admitted as observation on at 1408 and discharged on at 1512. The resident was observed, and no 1823 form required based on results of evaluation. A phone call should have been made to inform of return. Contact numbers have been provided for staff and copied to the Administrator of Nursing Supervisor and Emergency Room Manager." The Administrator was questioned regarding communication within the facility when a resident returns from the hospital, she stated that if a resident has had changes in condition a nurse will go to the hospital to determine appropriateness of re-admission to the facility. She stated in this case Resident#1 did not require any new orders, so he was discharged, the hospital case manager was not involved. The Administrator stated that Resident#1 was alert, oriented and she believes the hospital didn't ask which section of the facility he lived so they discharged him and didn't call the facility. In a confidential interview on at 10:30AM concerns were expressed regarding staffing, specifically that staff were not available, especially on the weekends and at night. Staff are not observed in the halls or going in and out of resident rooms. Additional concerns were expressed about staff coverage for buildings 4 and 5 due to the campus physical layout and staff	A 025		

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A 025	Continued From page 16	A 025		

having to provide required care services to residents and assistance to other care staff in both buildings, therefore potentially leaving their assigned building to provide coverage in the other.

Review of the staffing schedule for indicated on , care staff on duty were covering both buildings #4 and #5; there were four staff during the 7a-3p shift and four staff during the 3p-11p shift. The census on day of this survey, was 47 residents who are residing in building 5 and 13 residents residing in building 4.
In an interview with staff #B on at 9:05 AM, she stated that on the weekends, the nurse covers both buildings, and one care staff each shift is assigned to assist the residents with medications but will also have resident care assignments. She stated that leaves three care staff to cover residents in both buildings.

Review of the facility job description for care staff responsible for assisting with medications indicated the role responsibilities will include overseeing and assisting residents with personal care, including self-administered medication management and support with Activities of Daily Living (ADLs). These duties include: assisting residents with mobility by helping them get in and out of bed, chairs, or wheelchairs; assisting residents with activities of daily living such as bathing, , grooming, and toileting; positioning the resident in bed or in wheelchairs; assisting residents with eating and drinking, which can involve physically feeding residents who have difficulty feeding themselves or assisting with positioning food and utensils; assisting with light housekeeping tasks such as tidying resident rooms, changing bed linens, and

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A 025	Continued From page 17 maintaining cleanliness in common areas; supervising, assist or provide showers and baths; supervising, assist or toilet residents and assist or provide with supplies/care when appropriate and supervise, assist or transfer residents when necessary. In a follow-up interview with the Administrator at approximately 1:15 PM she stated that since the incident, they updated facility policy for any returning residents, the nurse will be notified. If there is no answer, then the hospital will contact the Administrator or Assistant Director. She stated that the facility campus has a 24/7 security guard at the entrance to the property who is responsible for stopping any transport vehicle and obtaining the resident's name, then calling the nurse. The Administrator stated that if the nurse does not answer, the security guard must contact the Administrator or Assistant Director. When questioned about off hours, what occurs, she stated that the building is open/unlocked from 8AM-8PM, and the front doors are locked at 8PM. During off hours, the security guard must contact the nurse or staff to allow access to the building. She stated there is no facility visitation restriction policy. When questioned about an unmarked transport vehicle, the Administrator stated that the security guard should be stopping all vehicles. She stated that after the incident, the concierge front desk staffing hours have been increased to daily, Sunday through Saturday, 8A-8P. When questioned how Resident#1 was allowed to access the building twice without any staff being aware of his return from hospitalizations, she stated the hospital failed to alert the facility of his return on both discharges. She acknowledged that the facility security did not stop the transport vehicles and did not contact/ notify the nurse on	A 025		

Agency for Health Care Administration

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A 025	Continued From page 18 duty for Resident #1's return to the facility and the care staff who had contact with the resident did not alert the nurse of his return. The facility was unable to provide documentation regarding any assessment of the implementation of the new protocols and procedures to prevent future reoccurrences and to ensure all staff (including the security guards and concierge) were appropriately trained regarding the updates. Class II	A 025		