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
	AL11969347	A. BUILDING: _____ B. WING _____	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEGANCE AT LAKE WORTH	9948 WOODWIND LANE LAKE WORTH, FL 33467

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A 000	Initial Comments AMENDED An unannounced Change of Ownership (CHOW), Licensure Complaints (#2025001091 & 2025009491) and Generator Monitoring survey was conducted on at Elegance at Lake Worth. The facility had deficiences related to the CHOW and Complaint 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	A 025		

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A 025	Continued From page 1 supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of 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 record review and interview, it was determined that the facility failed to ensure appropriate supervision was provided to a resident based on his/her care needs and diagnosis. It was also determined that the facility failed to maintain a general awareness of a resident residing in the facility for 2 out of 2 sampled residents (Resident #1 and #12). The findings included: Review of the facility's policy and procedure	A 025		

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A 025	Continued From page 2	A 025		

entitled, Basic Care with an Issued date of , documented the following.
Basic care will be provided to all residents on an individual basis according to findings from admission appraisals and subsequent re-appraisals.
1) All resident care is standardized, however, personal care plans should address any individual resident needs.
2) At the beginning of each shift, staff should familiarize themselves with resident status by attending the shift change and reviewing the 24-hour resident report.
3) Each resident should be monitored on an on-going basis as indicated in the service plan.
4) care is given as necessary to residents requiring assistance or full performance of care every two hours or per the resident's care plan.
5) Residents needing supportive care in the morning will receive assistance with the following activities as indicated on the service plan.
a) clothing selection
b)
c) oral care
d) hair care
6) Any unusual incident will be reported to the Director of Health and Wellness and documented. All pertinent information on the resident will also be documented and passed on the following shift.
7) Resident status changes will be reported to the Health Care Provider and resident's responsible party.

A) Review of facility progress notes dated documented the following.
a) At approximately 15:15(3:15PM), the front desk receptionist request nursing staff to open for the resident's family. A nurse

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A 025	Continued From page 3 proceeded to with the daughter. Upon entering the room observed resident unresponsive. Resident was to touch. Vitals taken, no , , no , , no , . Rescue call to evaluate. Rescue determined resident expired. Resident daughter was by her side. Writer call mortuary to arrange body pick. Mortuary picked up body and transported to Dorsey funeral home. No further documentation located in the resident's file regarding the facility's investigation or follow-up regarding the resident being found unresponsive. The file failed to document any witness(es) statements and/or documentation of care provided to the resident to determine the time and date the resident was seen alive. Therefore, the facility was unable to determine the length of time the resident was in her room. During an interview with Resident #1's representative on at 2 PM, it was revealed that numerous contacts were made to her mother on the date of the incident with no answer. The representative stated, due to no response from the phone calls to her mother, she went to check on the resident (her mother). Upon arrival and entrance to the room by access of the facility staff, this is the moment everyone identified the resident was . The facility had no knowledge of Resident #1's condition prior to the arrival of the family representative. Resident #1 is a 104-year adult that was admitted to the facility in 2021 after rehabilitation at a Nursing home. Resident #1 resided in the facility until her untimely on .	A 025		

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A 025	Continued From page 4 Review of Resident #1's Resident Health Assessment form (AHCA form 1823) dated , documented the following. The resident's medical history documented as , HOH (Hard of Hearing), OA( ), Iron Deficiency (IDA). Resident's physical limitations noted as uses walker for ambulation, HOH. The resident's or behavior status noted as alert and oriented x3(person, place and time). Nursing/treatment/ service requirements listed as N/A, resident has private caregiver. The resident special precautions noted as . Resident is documented as independent with ambulation, eating, toileting and transfering, and required assistance with bathing, and self-care. The form documents the resident has no meds. Further review of the resident's record revealed a completed and signed date . Review of Resident #1's Resident Functional Needs Assessment {Care Assessment Plan} dated documented that the resident was independent/no need.; total assessment score was zero. The resident's potential is documented as no known risk. Resident is documented as independent with in managing all medications, score of .025. The resident's coordination of care and services, Ancillary services coordination and Outside Provider were documented as independent/no need and no partial support from outside provider, respectively. Review of the facility's assessment plan and health assessment failed to also coordinate the actual level of care required by the resident.	A 025		

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A 025	Continued From page 5 Further review of the file reflected discrepancies regarding the actual care this resident required versus what was actually provided by the facility. The file filed to document daily care and services provided to this elderly resident. The facility failed to have a system in place to ensure a continuous line of care for the resident. During an interview with the Director of Wellness on at 1 PM, it was revealed that Resident #1 had a private duty aid daily for extended hours. The DON stated that the resident's care was mainly provided by her private duty aid. However, the facility was unable to confirm the exact time and days the private duty aide was present for the resident. The DON was also reminded that a private duty aide doesn't eliminate the facility's responsibility to supervise and provide care and services to a resident. She stated the facility really didn't provide any care and services to the resident since it was not a part of her care plan since she had a private duty aide. She further stated, that when a person has a private duty aid, the Health Assessment is modified to reflect a lower care requirement instead of the actual care needs of the resident. She confirmed that Resident #1's care needs per the Health Assessment form were not accurate due to the ARPN modifying it to reflect private duty services. B) On during a tour of the 2nd floor (northeast of the building) at 10:30 AM, a strong foul smell dominated the entire side. Upon approaching , the foul smell became stronger. Upon entering the room at 10:35 AM, it was noted that Resident #12 resided in the room. Resident #12 was observed to be extremely pacing the room, the carpet was noted	A 025		

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A 025	Continued From page 6 to be soiled in multiple spots, and the entire room had a and feces like smell throughout. The resident's clothing were noted to be disheveled. The multiple dresser drawers (2 in total) within the resident's room were noted to have locks on them. At this time, the resident was asked if anyone had assisted her with changing her undergarments and assisted to the bathroom. She stated, "No, I did it myself". However, the resident still had a strong odor smell in addition to the smell of the room. Further interview on at 10:45 AM with Resident # 12, she stated that she did not have a shower today and she got her self-dress. She stated that she always dresses herself. The odor in the room was extremely unbearable, that the surveyor, Director of Wellness (Staff B) and Assistant Director of Health and Wellness (Staff D) acknowledged the smell and had to exit the room to further discuss the condition of the resident. At 10:47 AM, Staff B was asked what services are provided to the resident. She stated the resident is noted as independent on the Resident Health Assessment, as the facility only provides what the family pays for. She acknowledged that the resident required assistance with her ADLs and that the Health Assessment was not current. She also stated the resident was extremely and had demonstrated a significant decline. Staff B and D stated at 11:05 AM on , the Health Assessments are filled out by the facility's Nurse Practitioner based on the services the resident pays for and not based on their actual care needs. Staff B acknowledged that this causes multiple discrepancies with the facility providing care and agreed that the Assessment should be reflective of the resident's care needs	A 025		

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A 025	Continued From page 7 and diagnosis. Staff F (Med-tech) was observed in the hallway near Resident #12 room, passing medications to the resident's on the 2nd floor. During an interview with Staff F on at 11:10 AM, she was asked if she had assisted Resident #12 with her morning medications, she stated "yes". She was also asked if she smelled the resident's room and assisted her with her toileting needs. She stated she didn't smell an odor in the room and didn't assist the resident with her toileting needs. On at 12:05 PM, Resident #12 was seen in the dining room seated with her table mate, resident was talking inconsistently and exhibiting further signs of . At this time the DOW was notified. The DOW was also asked to have staff monitor the resident as the resident was extremely , she agreed. Review of Resident #12's file revealed an admission date of . Resident #12's Health Assessment form dated documented the medical history as ( ), ( ), , Hx(history) of right , and . The resident's status was noted as Alert and Oriented x3 with mild /occasional . Special precautions for the resident noted as . The resident's ADLs are documented as independent with ambulation, eating, toileting and transferring and required assistance with bathing, and self-care. Review of Resident #12's Progress Notes revealed the following: a) (7:06 PM) -Nurse was called to resident room by staff member who informed	A 025		

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A 025	Continued From page 8 write resident and need assistance. Resident was observed seating on the floor in front of her chair, resident is alert and oriented to self, time, place and situation. Nurse ask resident how she resident stated, " I was in the kitchen getting some toilet paper to take to the bathroom when I slipped on the hardwood floor hitting y and , . No socks or shoes were observed on resident bilat . The floor was free of clutter and dry. A bump the size of an egg was observed on the of resident . Vitals was taken and within normal range. Resident was sent to the hospital. NP (Nurse Practitioner was notified and daughter was called and notified. DON (Staff B) and ADON(Staff D) were called and notified. b) (11:07 AM) - Received a call from a Care Staff stating to report to resident Unit, upon my arrival resident seen in a seating position on the floor. Resident denied hitting her and stating she was fixing her bed, when she finished, she sat at the edge of her bed, and she slid down. Resident assisted to a standing position and walked away with walker to her recliner. No , or discomfort reported by resident. Resident made aware of reports to care staff if any post symptoms arise. A call placed to APRN, and daughter are aware of the event. Class III	A 025		