

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969797	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/24/2025
NAME OF PROVIDER OR SUPPLIER BELLA MAR AT ROYAL PALM BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 11911 SOUTHERN BLVD PALMS WEST, 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 Limited Nursing Services (LNS) Monitoring survey was conducted on at Bella Mar at Royal Palm Beach. The facility had deficiencies at the time of the visit.	A 000		
AN278	59A-36.022(3) FAC; 429.07(3)(c)2, FS LNS - Records 59A-36.022 (3) RECORDS. (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained for each resident who receives limited nursing services from facility staff. (c) A nursing assessment conducted at least monthly must be maintained on each resident who receives a limited nursing service. 429.07 (3)(c)2, FS A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services from the facility's staff. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health... This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure required progress notes were completed for resident care of 2 of 2 sampled residents (Resident #1 and Resident #2) receiving Limited Nursing Service (LNS) for continuous use. The findings include:	AN278		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969797	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/24/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BELLA MAR AT ROYAL PALM BEACH

**11911 SOUTHERN BLVD
PALMS WEST, 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
AN278	Continued From page 1 1. Review of Resident #1's Resident Health Assessment form dated _____ revealed the resident was diagnosed with _____'s _____ and _____ (____). The resident is assessed to be easily _____ and requires supervision for bathing, _____, toileting and transfers. Review of Resident #1's progress notes showed the resident was readmitted to the facility on _____ after a hospital admission for treatment of a _____. Further review of the record indicated that the resident was ordered _____ (____) at 2L/min continuously via _____. Review of Resident #1's health care provider order dated _____ showed to administer at 2L via _____. Keep SAT (____ saturation) greater than 93%, may increase _____ to maintain SAT above 93%. Review of Resident #1's progress notes showed the resident was sent out to the hospital on _____ for complaints of _____ and _____. The resident is readmitted on _____ 5:14 PM with a diagnosis of _____. The resident was assessed by the nurse to have _____, with rales and _____ on auscultation. The resident remained on _____ at 2L via _____. The progress note did not have an SAT reading documented. Further review of the Resident #1's progress notes dated _____ 5:31PM showed the resident was noncompliant with keeping her _____ in place and was turning off the O2 concentrator delivery device. The note indicated that Resident#1 was encouraged to keep the	AN278		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969797	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/24/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BELLA MAR AT ROYAL PALM BEACH

**11911 SOUTHERN BLVD
PALMS WEST, 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
AN278	Continued From page 2 in place to ease her breathing. Review of the note indicated no SAT reading or assessment was completed by the nurse. Review of Resident #1's progress note dated 5:07 PM showed the resident was on LNS services for . The resident is noted with no and SAT 93%. Review of the note indicated no additional assessment by the nurse. Further review of Resident #1's progress notes showed the next note was dated at 12:54 PM. The resident was noted to have removed the and the nurse observed the resident and pale. The nurse administered the prescribed to the resident and recorded SAT reading at 93-95%. Further review of Resident #1's progress notes showed the next note was dated . 5:34 PM and revealed the resident was on LNS for continuous , the note did contain any nursing , assessment or SAT reading. Further review of Resident #1's progress notes showed the next note was dated 12:12 PM, indicating the resident continues to remove the and is encouraged to use the to ease her breathing. The next progress note dated 3:27 PM indicates Resident#1 is on LNS for use. The note did not contain any nursing , assessment or SAT reading. No additional progress notes were available for review. Review of an electronic medication order entry for	AN278		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969797	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/24/2025
NAME OF PROVIDER OR SUPPLIER BELLA MAR AT ROYAL PALM BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 11911 SOUTHERN BLVD PALMS WEST, 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
AN278	Continued From page 3 Resident #1 dated revealed a treatment as " SAT", to be scheduled daily every shift, passing times 12 AM, 8 AM and 4 PM. Resident is to wear at 2L at all times, indicated for Review of Resident #1's electronic medical record for " SAT" order indicated that facility staff were documenting the was in place three times a day since . Further review indicated that there were no SAT readings taken or recorded. In an interview with the facility nurse on at approximately 11:00 AM she stated that Resident#1 was on the LNS license for . When questioned when she performs a assessment including SAT reading to determine the prescribed SAT levels, she stated she documents the resident's SAT readings in her nursing notes. She acknowledged that she did not perform daily assessment and SAT testing. 2. Review of Resident #2's Resident Health Assessment form indicated the resident was diagnosed with . The resident was admitted to the facility on and required continuously. He was placed on the facility LNS for monitoring. Review of Resident #2's progress notes from showed the resident was using at 2L via continuously for . Further review of the residents' notes from to revealed no nursing assessment or , status was documented. Further record review revealed on at	AN278		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969797	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/24/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BELLA MAR AT ROYAL PALM BEACH

**11911 SOUTHERN BLVD
PALMS WEST, 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
AN278	Continued From page 4 4:14 PM Resident#2 had a complaint of _____ and was not utilizing the _____. The nurse documents vital signs which included an _____ SAT reading of 93%. The nurse documents the _____ concentrator unit was possibly _____ and a replacement was ordered. Further review of Resident #2's progress notes revealed the next note was dated 6:10PM revealed the resident was on LNS for continuous _____ use. Progress notes dated _____ and _____ indicated LNS for continuous _____ use. The notes did contain any nursing _____, assessment or SAT reading. No additional progress notes were available for review during the survey on _____. In an interview with the Director of Nursing on _____ at approximately 11:30 AM, she confirmed that Residents #1 and #2 were on LNS for _____ use. She stated that both residents were prescribed continuous _____ for _____ conditions. She stated that the nurses should be performing a nursing _____, assessment, including an _____ SAT reading at least daily and as needed since the residents were ordered continuous _____ administration. Class III	AN278		