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
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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
ZZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	ZZ830		

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
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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
ZZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	ZZ830		

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
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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
ZZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on interview and record review it was determined that the facility failed to submit its Comprehensive Emergency Management Plan (CEMP) to the local emergency management agency within 30 days of a significant modification. The findings included: During an interview with the Administrator on at 11:35AM, he stated the facility had experienced a change of management in and it was in the process of resubmitting both the EECP and the CEMP. At this time, all documentation related to the CEMP was requested. A review of the facility's CEMP documentation revealed the CEMP on file was approved under the name of the previous manangement. There was no documentation of a CEMP submission or approval under the current management. During an interview with the Administrator on at 5:35PM, he was informed that the facility was required to submit the CEMP to the local emergency management agency within 30 days of a significant modification,like a change in management or ownership. The Administrator acknowledged the findings. Class III	ZZ830		

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
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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, Limited Nursing Services (LNS), Complaint (#2025002374 and #2025010753) and Generator Monitoring survey was conducted on at Bella Mar At Delray Beach. The facility had deficiencies related to the Relicensure at the time of 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 agreed to by the facility and the resident,	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 010	Continued From page 1 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 notify the appropriate contact person in the	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 010	Continued From page 2 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, 2. The condition is documented in the resident's	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 010	Continued From page 3 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. (g) Continued residency criteria for facilities	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 010	Continued From page 4 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, interview and record review, it was determined that, the facility failed to provide an updated Health Assessment (AHCA Form 1823) to reflect a resident's change in condition, for 1of 2 sampled residents (Resident#13). The findings included: An observation during lunch, this surveyor observed Resident #13 being fed lunch by third party services aid (Hospice). During an interview on at approximately 12:15 PM with third party services aid, she stated Resident #13 is total care, unable to eat on her own. During an interview on at 12:17 PM, Staff M (Memory Care Director) was informed to provide Resident #13's file. She stated she is new on the position, but Staff O (facility nurse) can assist with providing the file and information regarding resident's care and services. Review of Resident#13s file revealed date of Admission of , further review revealed an AHCA Form 1823 dated that documented: a) Medical Diagnoses: , , , ( ). b) Activity of Daily Living (ADLs): marked as A - Needs Assistance (Staff provide physical assistance with the resident's participation) for: ambulation, bathing, , eating, grooming, toileting and transferring.	A 010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 010	Continued From page 5 c) Special Diet Instructions as mechanical soft/puree. d) Physical/Sensory Limitation: wheelchair for ambulation. e) ◡ or Behavior needs: severe without behaviors. During an interview on at approximately 2:30 PM the surveyor met with Staff B (Wellness Director) and Staff O they were both informed to provide an updated Health Assessment that documented change in condition for Resident #13. At this time, Staff B stated she was not aware AHCA Form 1823 did not reflect change in condition. She stated she was hired approximately 2 months ( ). They both acknowledged the findings. No additional documentation was provided. Class III	A 010		
A 028	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide supervision of or assistance with activities of daily living (ADLs) as needed for 2 of 5 sampled residents (Residents #9 and 10). The findings included:	A 028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 028	Continued From page 6 1) During a tour of the facility on at 10:39 AM, Resident #10 was observed in her living room ambulating with a wheelchair, while her husband (Resident #9) was receiving morning care from an unidentified provider. During an interview conducted with Resident #10 on at 10:41 AM, she stated that she had a private aid for Resident #9 that worked for 2 hours in the morning and 2 hours in the evening. She further stated that she is Resident #9's caregiver when the private aid is not there. Additionally, Resident #10 stated that she assists Resident #9 with eating, drinking, and transferring as needed. When asked if the care staff at the facility assists her with Resident #9's, Resident #10 stated they don't often. Resident #10 further stated that she also requires assistance with ، showering and occasionally transferring due to her condition, but she was more independent than Resident #9. A review of Resident #9's file revealed an admission date of . Further review of the file revealed a Resident Health Assessment (AHCA Form 1823) dated . The assessment stated the resident had diagnoses of ، ، collapse, and injury with a medical history of a left ، ، ، ، and ، . There were no nursing therapies or treatments he was receiving, however the resident was considered a risk. Resident #9 was documented as requiring supervision of ambulation, toileting, and transferring and independent for eating and grooming (other ADLs left blank). An additional review of the file revealed there was no service plan, medications or third party notes on file.	A 028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 028	Continued From page 7 A review of Resident #10's file revealed an admission date of . Further review of the file revealed a Resident Health Assessment (AHCA Form 1823) dated . The assessment stated the resident had diagnoses of , right drop , , , , Gammopathy of uncertain significance, , , and CKD3 with a medical history of (right) and , . There were no nursing therapies or treatments she was receiving, however the resident was considered a risk. Resident #10 was documented as needing supervision with ambulation and bathing; assistance with ; and independent for eating, grooming, toileting and transferring. An additional review of the file revealed there was no service plan, medications or third party notes on file. During an interview conducted with Resident #10 and representative of Resident #10 on at 2:06 PM, the representative stated that the facility was not meeting Resident #10's care needs. The representative further stated that both Resident #10 and Resident #9 have in their rooms on more than one occasion and the resident's private aid found them on the floor. Additionally, he stated that he was only made aware of the by the private aid and had never received contact from the facility. The representative then stated he was aware that Resident #10 was providing ADL care to Resident #9, however, he felt as though it was unsafe due to Resident #10 having drop and being unable to use one entire (right). Subsequently, he stated that both Resident #9 and Resident #10 need their ADLs needs met and the facility was failing to do so, which put both residents at risk of harm or injury.	A 028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 028	Continued From page 8 While the interview was occurring on at 2:30 PM, Resident #10 was observed jumping off of the couch into her wheelchair to provide ADL assistance to Resident #9. Resident #10 stated, "He's making too much noise I think he needs water." Resident #10 then quickly ambulated to the kitchen to grab a bottle of water, almost knocking items off of the kitchen counter. At this time, Resident #2 entered the room and Resident #10 frantically stated, " Resident #9 needs help, can you help me give him this water." Resident #2 took the water bottle from Resident #10 and provided assistance to Resident #9. Resident #9 began sliding down the bed and Resident #2 and Resident #10 could not continue to provide ADL assistance. Resident #9 was observed holding on to the bedrails on his bed to prevent himself from sliding off. Resident #10 then asked the surveyor if she could please get someone to help her. At this time, AHCA intervened and went towards the front desk to call for help. Staff K (caregiver) and Staff H (caregiver) were present in the hallway, and the surveyor requested they assist Resident #9 to prevent him from falling off of the bed. Staff K, Staff H and the surveyor reentered the room and Staff K and Staff H proceeded to adjust Resident #9's position on the bed. Resident #10 began crying and stated she was thankful for the assistance. During an interview conducted with the Health and Wellness Director on at 3:24 PM, she was asked for documentation of the care level assigned to both Resident #9 and Resident #10 how the facility was implementing service to meet their ADL care needs. The Director stated she had no documentation currently available for residents that show assigned care levels for staff and residents to sign-off. She further Some	A 028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 028	Continued From page 9 residents have service plans and some residents do not, and Residents #9 and #10 do not at this time. When asked how their current care needs were being met, the Director stated that care needs were built into their previous service plan but the plan had not been updated. At this time, she was informed that both residents were observed needing assistance throughout the day and facility had not been meeting their care needs. Furthermore, she was informed that failure to reassess the residents and immediately implement a new care plan was putting the residents at risk of harm or injury. The Director acknowledged the findings. 2) During an interview conducted with Resident #10 on at 10:44 AM, the she stated that when either her or Resident #9 needed immediate assistance with their ADLs they use the call pendant. She further stated that the staff had not been responding timely to her calls and she felt the need to independently assist Resident #10. During an interview conducted with a representative of Resident #10 on at 2:10 PM, he stated that Resident #10 and Resident #9 complained of using the call pendant in times of urgent need and the staff did not come. He further stated during the previous week, on , Resident #9 needed urgent assistance and Resident #10 had wheeled herself to the front desk to get assistance because the response time was taking too long. During an interview conducted with the Health and Wellness Director at 3:49 PM, a request was made for the call bell response documentation. Documentation was provided.	A 028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 028	Continued From page 10 A review of the facility's call bell response for the month of ⌄ provided by the Health and Wellness Director revealed the following information: Pendant Alarm Print out for Resident #9 and #10's Room - # of Call Responses over 10 minutes: 12 - # of Call Responses 15+ minutes: 8 - Longest wait time: 37 minutes on During an interview conducted with the Health and Wellness on at 4:20 PM, she stated that she was aware of the lengthy call response times. She further stated she was constantly in-servicing staff on the wait times and had begun implementing disciplinary action due to a lack of improvement. Documentation was requested. A review of the in-service and disciplinary action documentation revealed the following: In-services were completed on following dates radio response and call light times: (Staff M attended) (Staff M and Staff N attended) Disciplinary Actions that were implemented as a result of the in-services: -Staff M (caregiver) received a disciplinary action on for having a call light wait time over 40 minutes -Staff N (caregiver) received a disciplinary action	A 028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 028	Continued From page 11 on for having two call light times over 20 minutes and one call light time over 40 minutes. During an interview conducted with the Administrator and the Health and Wellness Director on at 5:35 PM, they were informed that the call response times for the month of indicate that the staff are not performing the ADL care as needed for Resident #9 and Resident #10. Additionally, they were informed that despite the in-services performed, the residents were still experiencing extended wait times when they call for assistance. Furthermore, it was stated that in addition to reassessing the residents, to receive appropriate ADL care, the staff need to implement the ADL plans assigned to these residents by responding timely to their needs. They acknowledged the findings. Class III	A 028		
A 031	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 031	Continued From page 12 coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 031	Continued From page 13 timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on interview, observation, and record review, it was determined that, the facility failed to coordinate with a third party provider to deliver care and services that met the residents' needs and ensured eligibility for continued residency. This was evidenced by the facility's failure to implement the facility's policy for the documentation, coordination, and supervision of third party services for 1 out 3 sampled hospice residents (Resident #9), The findings included: A review of the facility's third party policy titled, "THIRD PARTY PROVIDERS"[Policy Date:], revealed the following information: Policy: As residents age in place and experience a decline in their ability to provide self-care, they may need to receive additional support from a Third Party service provider. Criteria for continued residency may depend on utilization of these services. The service should be provided in accordance with resident's service plan. Third	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 031	Continued From page 14 Party Provider Services require an order from the resident's healthcare provider. The resident's right to select a Third Party Provider is allowed and respected. The Health and Wellness Director is responsible for the facilitation, coordination and collaboration of care and services provided by a Third Party Provider. NOTE: State Regulations supersede company policy. Procedure: 1. List. Health and Wellness Director provides a list of Third Party Providers for residents/responsible parties to make choices. 2. Selection. Resident/Responsible Party independently arrange, contract and pay for services provided by a third party of resident's choice (e.g., licensed home health agency, private nurse, outpatient clinic). 3. Assistance by ED/HWD. When residents/responsible parties arrange for third party services, General Manager or Health and Wellness Director will assist in facilitating, coordinating and collaborating provision of ordered services. If community's efforts at facilitation, collaboration and coordination are unsuccessful, the Health and Wellness Director will notify healthcare provider and responsible party. 4. Third Party's Responsibilities. The third-party provider will: a. Coordinate with the community regarding resident's service plan and follow community standards and policies in delivery of those services. b. Provide weekly communication of resident	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 031	Continued From page 15 clinical status related to ordered care and services, including documentation in third party record. c. Notify Health and Wellness Director about resident progress, changes in treatments, visit schedule, community follow-up support, etc., after initial visit and weekly. d. , be asked to attend service plan meetings to ensure continuity of delivery of services 5. Criteria. The services provided to resident must meet criteria for continued residency. Updating Service Plan. The Health and Wellness Director is responsible for updating the resident service plan to reflect third party provider services. 6. Filing. The Third-Party Provider Services order is filed in the resident record. 7. Declination. Declination of healthcare ordered for third party assistance is communicated to the healthcare provider and responsible party. The resident declination and communication of consequences of refusal is documented in resident record by a Licensed Nurse and or healthcare provider. During a tour of the facility on at 10:43 AM, Resident #9 was observed receiving care and services from an unidentified service provider. While the unidentified provider was attempting to assist Resident #9 with a transfer, the resident began . The unidentified provider then stepped out of the room and stated she would return. During an interview conducted on at 10:46 AM with Resident #10, she stated that she	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 031	Continued From page 16 was his spouse and the two lived together. She further stated that Resident #9 was diagnosed with a after being in remission for many years. Resident #10 then stated that the unidentified provider was the Hospice Nurse and Resident #9 was receiving hospice services as the previous Friday ( ) When asked if the Administrator or Health and Wellness Director knew, Resident #10 stated neither of them had seen her husband (Resident #9) since he enrolled in hospice services. During an interview conducted with the Health and Wellness Director on at 11:31 AM, she stated that she only had two residents receiving hospice services currently. When asked about Resident #9, she stated she was not aware of his enrollment in hospice services at this time. The Health and Wellness Director was informed that Resident #9 had been enrolled in hospice services since and that a Hospice Nurse was currently onsite providing care and services to the resident. During an interview conducted with the hospice nurse in the presence of the Health and Wellness Director, Resident #9, and Resident #10 on at 11:40 AM, the nurse confirmed that Resident #9 was admitted to hospice on and had been receiving services since. At this time, the Health and Wellness Director responded that she was not aware of this and hospice did not coordinate with her at all on the enrollment of the resident. She further stated that the Hospice Provider performed a consult on but did not tell her they were enrolling the resident. As a result of this discussion, Resident #9's file was requested for review.	A 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 031	Continued From page 17 A review of Resident #9's file revealed an admission date of , Further review of the file revealed a Resident Health Assessment (AHCA Form 1823) dated . The assessment stated the resident had a medical history of , , , , and , . There were no nursing therapies or treatments he was receiving. An additional review of the file revealed there was no service plan, third party notes, or Interdisciplinary Plan of Care from hospice on file for the resident. During an interview conducted with the Health and Wellness Director on at 3:24 PM, she stated that there was no care level or service plan available on file for Resident # because the facility was in the process of manually reassessing the residents after a change of management. She further stated that Resident #9's file was not a priority for the facility because they were focusing on reassessing the residents in Memory Care first. Additionally, she stated that there were no third party notes or Interdisciplinary Care Plan on file because she was not aware that the resident was enrolled in hospice services. She stated she was going to contact the hospice service that day. At this time, she was informed that the facility had failed to coordinate care and services with Resident #9's hospice provider per the facility's policy. Furthermore, she was informed that the hospice provider was providing care without her knowledge, which further violated the facility's policy. The Health and Wellness Director acknowledged the findings. Class III	A 031		
A 036	59A-36.007(10) PROCEDURES CONTROL	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 036	Continued From page 18 (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation, and interview, it was determined that, the facility failed to ensure staff implemented Control Procedures when assisting with Self-Administration of medication during a Medication Pass (Med Pass) for 1 of 3 sampled residents (Resident #18). The findings included: An observation during a Medication Pass on (outside the nurse's station) in the	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 036	Continued From page 19 Memory Care Unit (MCU) at approximately 12:50 PM, this surveyor observed Staff N (Medication Technician) putting the following medication on the floor (carpet) for Resident #18: - 1% gel, apply two grams , , to both four times daily: 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM. Further observation revealed Staff N removed the medication tube from its container (box) and unscrewed the tube cap. Resident #18 was sitting in her wheelchair, Staff N kneeled on the floor and proceeded to put the mentioned items on the carpet. During an interview on at approximately 1:15 PM with Staff N, he acknowledged the findings. During an interview on at approximately 1:25 PM surveyor met with Staff B (Wellness Director) and she was informed of the findings. Class III	A 036		
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	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 20 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 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	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 21 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 staff interview, the facility failed to ensure 1 of 4 sampled staff (Staff A) had provided within 30 days of hire, a written statement from a health care provider documenting that this individual did not have any signs or symptoms of communicable , ( ); and 3 of 4 sampled staff (Staff A, Staff D, and Staff F) had provided evidence of a negative ( ) examination on an annual basis. The findings included: A review of Staff D's (Med Tech) personnel file revealed a hire date of . Staff D's personnel file did contain a written statement from a health care provider, dated , documenting that this staff member was free from any signs and symptoms of communicable , including . However, there was no further documentation of negative exams completed on an annual basis for years 2024 or 2025. A review of Staff F's (Direct Caregiver) personnel	A 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 22 file revealed a hire date of . Staff F's personnel file did contain a written statement from a health care provider, dated , documenting that this staff member was free from any signs and symptoms of communicable , including . However, there was no further documentation of negative exams completed on an annual basis for years 2024 or 2025. A review of Staff A's (Administrator) employee file revealed a hire date of . Staff A's employee file provided no written statement from a health care provider documenting that this staff member was free from any signs and symptoms of communicable , including , within 30 days of hire date, or anytime thereafter. There was also no documentation of the annual negative exam for 2024 or 2025. On at 3:30 PM, Wellness Director (Staff B) confirmed that she was unable to find the necessary health documents in Staff A, Staff D, Staff E and Staff F's record. On at 4:00 PM, the Administrator confirmed that they are unable to provide the necessary documentation to show compliance with the required medical information. Class III	A 078		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 081	Continued From page 23	A 081		

the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record.
(b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d).
(c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a).

(7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.

59A-36.011
(2) STAFF PRESERVICE ORIENTATION.
(a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 081	Continued From page 24 completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 081	Continued From page 25 chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 081	Continued From page 26 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that three 3 of 3 staff members (Staff D, E, F) had completed and signed a statement that they completed the required 2-hour pre-service orientation documentation. The findings included: A record review of Staff D's personnel file revealed a hire date of as a Med Tech. Staff D has direct contact with the residents' when they provide direct care and services to the residents. Further review of personnel file revealed no evidence of a signed statement that they completed the required 2-hour preservice orientation. A record review of Staff E's personnel file revealed a hire date of as Med Tech. Staff E has direct contact with the residents' when they provide direct care and services to the residents. Further review of personnel file revealed no evidence of a signed statement that they completed the required 2-hour preservice orientation. A record review of Staff F's personnel file revealed a hire date of as Direct Care Staff. Staff E has direct contact with the residents' when they provide direct care and services to the residents. Further review of personnel file revealed no evidence of a signed statement that they completed the required 2-hour preservice orientation.	A 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 081	Continued From page 27 During an interview with the Administrator and the Wellness Director on at 4:30 PM, they agreed staff are required to have an orientation. The Administrator and the Wellness Director are aware the personnel are missing some of the required training. Class III	A 081		
A 082	59A-36.011(4) FAC Training - / (4) . . / . (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. 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 that within 30 days of employment staff obtained required training for / . (/), for 3 out of 3 sampled staff (Staff D, E, and F) The findings included: A record review of Staff D's personnel file with a hire date of did not have documentation for completing an education course on and	A 082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 082	Continued From page 28 . A record review of Staff E's personnel file with a hire date of did not have documentation for completing an education course on and . A record review of Staff F's personnel file with a hire date of did not have documentation for completing an education course on and . During an interview on at approximately 4:25 PM the Administrator acknowledged the findings. No additional documentation was provided during the survey. Class III	A 082		
A 083	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement.	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 083	Continued From page 29 (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that at least one (1) staff member who holds a currently valid First Aid and , , ( ) certification card is in the facility at all times. The findings included: Staff D, who was hired , works the 3:00 PM to 11:00 PM (second shift). A record review on of the employee file revealed no evidence that they completed the , , ( ) and First Aid certification training courses. Further review of the personnel file revealed no evidence of documentation of a current certification. Staff F, who was hired , works the 11:00 PM to 7:00 AM (third shift). A record review on of the employee file revealed no evidence that they completed the , , ( ) and First Aid certification training courses. Further review of the personnel file revealed no evidence of documentation of a current certification. During an interview on at 4:00 PM with the Wellness Director, she was informed there must be at least one (1) employee on each shift that holds a valid and First Aid certification card. She was asked to provide	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969859	A. BUILDING: _____ B. WING _____	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA MAR AT DELRAY BEACH	14100 VIA FLORA DELRAY BEACH, FL 33484

(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 083	Continued From page 30 documentation/certifications for an alternative staff member that work aforementioned shifts. The Wellness Director stated that she maintains all the and First Aid certifications in a 3-ring binder That is located in her office, and she will bring the binder for review. On at 4:35 PM, the Administrator and the Wellness Director were informed of the missing documentation, no further documentation was provided at the time of survey. Therefore, the facility was unable to prove they had atleast one person that was certified and trained in First Aid and for 11:00 PM to 7:00 AM (third shift) and 3:00 PM to 11:00 PM (second shift). Class III	A 083		