STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105516	A. Building B. Wing	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Darcy Hall of Life Care	2170 Palm Beach Lakes Blvd West Palm Beach, FL 33409

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, record review, and review of the shower binder, the facility failed to honor resident's choice for receiving and scheduling of showers for 1 of 2 sampled residents (Resident #117). The findings included: Record review revealed Resident #117 was admitted to the facility on [DATE] with pertinent diagnoses of Dementia with behavioral disturbance, and Malignant Neoplasm of Colon. Review of Resident #117's Annual Minimal Data Set (MDS) assessment dated [DATE], section F, revealed that it is very important for the resident to choose between a tub bath and a shower. The MDS also documented Resident #117 requires a one-person physical assist for bathing and for Activities of Daily Living (ADLs). During the initial tour of the facility conducted on Monday, 10/02/23 at 10:12 AM, Resident #117 was observed in his wheelchair waiting in the hallway. When the surveyor greeted Resident #117, he stated I want a shower. The surveyor returned to the unit at 12:35 PM, Resident #117 was still waiting in the hallway for a shower. Review of the facility's daily shower list revealed that Resident #117 is scheduled to have a shower on Tuesdays and Fridays (Photographic evidence obtained). An interview was conducted on 10/04/23 at 11:00 AM with Staff B, Certified Nursing Assistant (CNA), who provides care for Resident #117, regarding the facility's shower protocol. Staff B stated that he obtained the list of residents scheduled for showers for the day at the Nurses' station. He then stated that residents are offered showers once a week. If the resident refuses the shower, he lets the nurse know, then he tries again in 15 minutes to see if the resident changed their mind. If they refuse again, he lets the nurse know so the nurse can document. He fills out a Bathing & Skin report for the resident and documents on the computer in the Point of Care (POC) section. On 10/04/23 at 3:10 PM, an interview was conducted with Staff C, Registered Nurse (RN) regarding the facility's shower protocol. Staff C stated that the CNA would let her know if residents agreed or refused to shower. The CNA will fill out the Bathing & Skin report for each resident. Then she will sign the report and the CNA will put the report in the shower binder located at the Nurses' station. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/04/23 at 3:18 PM, an interview was conducted with the [NAME] unit manager and was asked to explain the shower protocol. She stated that if the resident is scheduled for a shower in the 7 AM - 3 PM shift and refuses, then the staff will try again in the 3 PM -11 PM shift on the same day. If the resident still refuses, the staff will try again the next day. The surveyor asked if the CNA fills-out a report each time there is an attempt to have the resident showered. The unit manager stated that all CNAs will fill-out the report each time the resident receives a shower or refuses. Plus, the CNA will document it on the POC. The Shower binder (where the Bathing & Skin reports are kept) revealed that Resident #117 had showers only on 09/02/23 and 10/02/23. The record lacked any evidence of a shower preference for Resident #117. Furthermore, the facility's shower schedule was not followed for Resident #117 and refusal of any showers on the scheduled days was not documented. (Photographic evidence obtained). During a follow up interview with Resident #117 on Thursday, 10/05/23 at 11:45 AM, he was asked how often he would like a shower. Resident #117 stated he would like to get showers every other day at least. The surveyor asked the resident if the staff has asked him if he wanted a shower since Monday 10/02/23 (Resident's last documented shower date), Resident #117 stated no. During an interview on 10/04/23 at 3:20 PM, the unit manager was asked to provide documentation for showers (whether in the shower binder or on the computer) for Resident #117. The unit manager was unable to show documentation of any times Resident #117 refused a shower within a 30-day period.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49060 Based on observations, interviews, record reviews, and policy review, the facility failed to dispose of expired medications in 1 of 5 medications carts (Southwest unit), affecting Resident #30, and in 1 of 2 medication storage rooms (Southwest unit); and failed to ensure the proper route of administration in the labeling of medications for 1 of 7 sampled residents observed during medication administration observations (Resident #32). The findings included: Review of the facility's policy title Storage and Expiration Dating of Medication, Biologicals, dated 12/01/07, revealed the following: Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other Applicable Law, and in accordance with Policy 8.2 (Disposal/Destruction of Expired or Discontinued Medication). Policy 8.2: Facility should place all discontinued or outdated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction. Facility should request that Pharmacy perform a routine nursing unit inspection for each nursing station in Facility to assist Facility in complying with its obligations pursuant to Applicable Law relating to the proper storage, labeling, security and accountability of medications and biologicals. 1) A medication storage cart observation was conducted on 10/05/23 at 11:46 AM on the Southwest unit with Staff A, Registered Nurse (RN). Upon inspection of the cart, a small plastic clear zip-lock bag labeled with Resident #30's name, the name of the medication (Ondansetron, a medication for nausea), and dated 08/22/22. This surveyor showed the medication to Staff A, in which he stated that the resident still resides at the facility, and the medication is an as needed (PRN) medication. However, he had not noticed the expiration date (Photographic evidence obtained). Record Review of Resident #30 physician's orders revealed the medication was discontinued on 01/17/23. 2) A medication storage room observation in the facility's [NAME] unit was conducted on 10/05/23 at 11:55 AM with Staff A, RN and the unit manager. While inspecting the over-the-counter (OTC) medications, an observation was made of a Geri-Lanta Regular strength bottle which had an expiration date of 09/23, and a box of Acetaminophen Suppositories 650mg with an expiration date 03/23 (Photographic evidence obtained). The unit manager was made aware and agreed that the medications were expired and needed to be removed. 25404 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) A medication pass observation for Resident #32 was made on 10/04/23 at 9:01 AM, with Staff A, Registered Nurse (RN). The RN obtained six medications that included Losartan (a blood pressure medication) 50 mg (milligrams). The RN crushed the medications and administered them to Resident #32 via her PEG (percutaneous endoscopic gastrostomy, a surgical procedure for placing a feeding tube). Review of the label of the Losartan packaging documented the losartan was to be given by mouth (Photographic Evidence Obtained). Review of the physician order dated 09/10/23 documented the Losartan was to be given via the PEG tube. During an interview after the medication administration, when asked about the route of medications for Resident #32, Staff A, RN, explained the resident used to take all of her medications by mouth, but a few weeks prior, Resident #32 stopped eating, was sent to the hospital, and now has a PEG tube. Staff A agreed the medications were to be given to Resident #32 through her PEG. The RN obtained a Direction Change sticker from the medication cart, placed it on the Losartan packaging, and explained the proper process.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 01948 Based on observation, interview, and record review, the facility's approved menu was not followed for 16 residents (includes sampled Resident #16, #20, #54, and #72) with physician ordered Pureed Diet for, 17 residents (includes sampled Resident #70) with physician ordered Easy To Chew Diet, and 14 residents (includes sampled Resident #28, #59, and #125). The findings included: 1) During the review of the approved facility menu to be served for the lunch meal on 10/02/23, the following were noted: Regular Diet: Kielbasa (4 ounce edible portion) Regular Diet: Potatoes O'Brien, Fruit Crisp Easy To Chew Diet: Ground Pork Roast, Soft Potatoes O'Brien, Soft Fruit Crisp Mechanically Altered Diet: Ground Pork Roast, Soft Potatoes O'Brien, Pureed fruit Crisp Pureed Diet: Pureed Pork Roast, Pureed , Soft Potatoes O'Brien, Pureed fruit Crisp Regular Diet: Potatoes O'Brien Alternate Regular Diet: Chop Steak (4 ounce Edible Portion) Alternate Regular Diet Starch: Buttered Corn Alternate Easy To Chew Diet & Mechanical Altered Diet: Buttered Corn Alternate Pureed Diet: Pureed Buttered Corn During the observation of the lunch meal in the main kitchen on 01/03/23 at 11:45 AM, the following were noted: < Easy To Chew Diet, Mechanical Altered Diet, Pureed Diet: Ground Pork Roast and Pureed Pork Roast were not prepared or served. Kielbasa was served < Easy To Chew Diet , Mechanical Altered Diet, and Pureed Diet: Soft Potatoes O'Brien and Pureed Potatoes O'Brien were not prepared or served. Roasted Potatoes were served. < Easy To Chew Diet , Mechanical Altered Diet, and Pureed Diet: Soft Fruit Crisp and Pureed Fruit Crisp were not prepared or served. Watermelon was served. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	< Easy To Chew Diet, Mechanical Altered Diet, and Pureed Diet: Buttered Cord was not prepared or served. Instant Mashed Potatoes were served. < Entree portions were weighed utilizing the facility's calibrated portion scale were conducted. The weighing noted that an average portion of Kielbasa was only 3 ounces, and average portion of Chop Steak Was only 2. 75 ounces. 2) During the review of the approved facility menu for the breakfast meal of 10/03/23, the following were noted: Pureed Diet:#8 Scoop of Pureed Hot Cereal Easy to Chew : #16 Scoop Bacon Mechanically Altered : #16 Scoop Bacon Pureed Diet: #16 Scoop Pureed Bacon Observation of the meal tray assembly line in the main kitchen on 10/03/23 at 7:30 AM noted the following: 1) Pureed Hot Cereal not prepared or served. 2) Easy to Chew and Mechanical Altered Bacon was not prepared or served 3) Pureed Bacon not prepared or served. * Review of the facility's approved diet manual on 10/03/23 noted that pureed bacon must be commercially prepared and purchased. Interview with the Food Service Director on 10/03/23 noted that commercially prepared bacon is not purchased. 3) During the review of the approved menu for the lunch meal of 10/04/23, the following were noted: Mechanically Altered: 2 Ounces Ground Meatball (2 ounces), Cut Up Noodles (4 ounces), Pureed Diet : Pureed Meatball (2 ounces) Easy To Chew: Cut Up Noodles (4 ounces) Alternate Entree (Regular) : Grilled Shrimp (3 ounces) Alternate Entree (Easy To Chew): Cut Up Shrimp (3 ounces) 4) During the review of the facility's Diet Census for 10/03/23, the following were noted: (a) Current Physician Orders for Pureed Diet = 16 Residents : Includes Resident #16, #20, #54 and #72. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(b) Current Physician Orders for Easy To Chew Diet = 17 Residents: Includes Resident #28. (c) Current Physician Orders for Mechanical Altered Diet = 14 Residents: Includes Resident #28, #59, and #125.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32078 Based on observations, interviews and record reviews, the facility failed to provide adaptive eating equipment as per Occupational Therapy (OT) assessment and orders for 3 of 8 sampled residents reviewed for nutrition (Resident #70, #41 and #164). The findings included: 1) Resident #41 was admitted to the facility on [DATE] with diagnoses which included Dysphasia, Alzheimer's, Dementia, Depression, Anxiety, Gastroesophageal Reflux Disease, Hypothyroidism, and Protein Calorie Malnutrition. During record review for Resident #41, an order for Adaptive Equipment, dated 04/11/23, required dycem under plate, foam handled built-up utensils, 2 handled cup with lid and straw, and divided plate for all meals. Resident #41's OT Assessment Discharge Summary, dated 06/08/23, recommended for Feeding: 3 compartment divided plate, dycem under the plate, foam built up utensils and 2 handled cup with lid and straw. A weight change note dated 07/07/23 and a dietary note, dated 07/15/23, both documented that Resident #41 was to be provided with dycem under plate, foam handled built-up utensils, 2-handled cup with lid and straw, and divided plate with all meals. Resident #41's latest Care Plan related to resident's nutritional problem or potential for nutritional problem, dated, 09/18/23, included the following interventions: OT to screen and provide adaptive equipment for feeding as needed - Divided plate, 2 handled cup with lid and straw, foam handled built-up utensils on all trays. During a lunch observation on 10/02/23 at 11:31 PM, Resident #41 was observed eating her lunch, independently, in the dining room. During this meal, Resident #41 was not provided a Dysem (non-stick pad) under her plate, nor was she given a built-up knife to cut up her food. Both of these missing items were listed on her meal ticket as being required during meals. On 10/04/23 at 1:00 PM during a second lunch observation, it was noted that Resident #41 had received a dysem under her plate; however, at this time, she was not provided with a weighted fork, only a weighted spoon and knife (photographic evidence obtained). 2) Resident #70 was admitted to the facility on [DATE] with diagnoses which included End-Stage Renal Disease, Hemiplegia and Hemiparesis following cerebral infraction, Dysphasia, Protein-calorie Malnutrition, Diabetes Mellitus 2, Dementia, Depression, and Gastroesophageal Reflux Disease. During record review for Resident #70, an order for adaptive devices, dated 07/18/23, specified: Patient to have built up foam utensils, divided plate, 2 handle cups with straw lids for all meals. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #70's OT Assessment Discharge Summary, dated 08/01/23, recommended for Self-Feeding: Divided plate, 2 handled cup with lid and straw, and foam built-up utensils. A dietary note, dated 07/15/23, documented that Resident #70 was to be provided with adaptive equipment: built up foam utensils, divided plate, 2-handeled cup with straw and lid. Resident #70's latest Care Plan related to resident's altered nutritional needs, dated, 08/07/23, included the following interventions: Adaptive equipment as ordered (built up foam utensils, divided plate, 2 handled up w/lid). During lunch observation on 10/04/23 at 1:10 PM, it was noted that Resident #70 did not receive foam built-up utensils or a 2 handled cup with straw and lid (photographic evidence obtained). Interview with Director of Rehabilitation on 10/05/23 at approximately 1:00 PM confirmed OT assessments and adaptive equipment orders for Resident #41 and #70. 25404 3) An observation on 10/02/23 at 1:35 PM, Resident #164 was observed eating in the [NAME] Unit Dining Room. Review of the menu ticket documented to use a Dycem (non-stick pad). A second meal observation on 10/03/23 at 9:23 AM revealed a lack of Dycem on the tray of Resident #164. Review of the record revealed Resident #164 was admitted to the facility on [DATE]. A physician order dated 06/25/23 documented the use of the Dycem under the resident's meal plate as adaptive equipment needed. Nutritional assessments dated 07/20/23 and 09/19/23 also documented the use of the Dycem. Review of the current care plans revealed the use of the Dycem non-skid pad beneath the plate during meals, as adaptive equipment. Review of the OT (occupational therapy) Discharge Summary for Resident #164, for the service period of 07/19/23 through 08/09/23 documented the discharge recommendation of Dycem under the resident's plate in order to facilitate self feeding, and that the order was placed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 01948 Based on observation and interview, it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for potentially 175 of the facility resident's. The findings included: 1) During the initial kitchen/food service observation tour conducted on 10/02/23 at 9:15 AM and accompanied with the with the Food Service Director and Regional Administrator, the following were noted: (a) Ceiling mounted air-conditioning vent and drip pan located above food preparation surfaces and the 3-compartment sink was noted to be soiled and full of condensation. Further observation noted that the contaminated condensation was dripping down on food preparation counters, 3-compartment sink area, and the floor area under the vent. It was discussed with the Food Service Manager (FSD) that there was a potential of contamination from the dripping condensation. The surveyor requested that staff not have access to the areas surrounding the vent and drip pan until the issues was resolved. (b) The commercial plate warmer located on the tray line serving area was noted to be soiled and to have a heavy build-up of dried food matter. The surveyor discussed with the FSD that the soiled warmer was contaminating clean plates. (c) A personal staff purse was noted to be stored directly on top clean disposable dishware. The surveyor discussed with the FSD that the purse was potentially contaminating the disposable dishes. (d) Observation of the Victory Reach-in refrigerator #1 noted to have 9 of 9 food storage shelves the were heavily rust laden and in need of replacement. It was discussed with the FSD that the reach-in unit not be used until the food storage shelves were replaced. (e) Observation of the dish machine noted that 1 of the 3 internal separation curtains located within the machine was missing. The machine was in use without the curtain and the surveyor informed the FSD that the internal curtain separate dirty, clean and sanitizing sections of the machine and that there was a potential to contaminate clean dishes exiting the machine. (f) The lens covers of 3 commercial ceiling lights were noted to be broken and had large cracked areas. The surveyor discussed with the FSD that there was the potential of broken plastic light lens to fall into prepared foods. 2) During the second follow-up visit to the kitchen/food service department on 10/03/23 at 7:30 AM noted the following: (g) The second ceiling air conditioner vent located over the tray line area was noted to have a heavy build-up of black mold type matter around the unit and ceiling area. There was a potential of food contamination and food borne illness from the molded area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(h) Numerous observations of residents eating plates (10) were noted to have a heavy yellow stain of the entire eating exterior. The surveyor requested that all stained plates be removed and discarded. (i) During the observation of the tray line food, temperatures were taken by the use of the facility's calibrated digital food thermometer. The results of the temperature testing noted that cold foods were not being held by the regulatory requirement as evidenced by: * Non-fat Yogurt (10 servings) = 54 degrees F * Honey Thick Milk (8 portions) = 49 degrees F * Individual Orange Juice (40 servings) = 46 degrees F Photographic evidence obtained for all examples.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. 01948 Based on observation, interview, and record review it was determined that the facility failed to provide ceiling suspended curtains which provides total visual privacy for 3 of 3 sampled residents (Resident #16, #20 and #72), reviewed for privacy. During the screening of facility residents on 10/02/23 at 10:30 AM, it was noted that Resident #16, #20, and #72 occupied a room together. Further observation noted that there were no privacy curtains between the beds of beds of Resident #16 and #20, and only a small curtain between the beds of Residents #16 and #72. Further observation noted that the hooks were on the ceiling tracks without the curtains present and there was no privacy between all three resident beds. It was also noted that the 3 resident's had some cognition issues and required total care. On 10/03/23 at 9 AM, a second observation was made of the room and it was again noted that there were no privacy curtains present in the room and indicating the facility was not providing privacy for the residents during care. Following the second observation the issues was brought to the attention of the facility's administration who accompanied the surveyor to the room and confirmed the surveyors findings of no privacy curtains present for Resident #16, #20, and #72. On 10/03/23 at 2 PM the facility administration submitted documentation to the surveyor acknowledging that all residents are to be provided with privacy and all facility staff (65) were in-serviced that missing resident privacy curtains are to be reported immediately to Environmental or Maintenance Department . On 10/04/23 at 11 AM, an interview was conducted with the E Wing Unit Manager to discuss the privacy curtain issue. It was noted from the interview that she was not made aware from the unit staff that there were no privacy curtains located in the room of Resident #16, #20 and #72. It was also discussed that she could not imagine staff giving care to Resident #16, #20, and #72 without privacy curtains present . It was also noted that it could not be determined how long the privacy curtains were missing. During the review of the clinical records of Resident #16, #20, and #72, the following were noted: Resident #16: Date Of Admission: 07/11/20 (Current Hospice) Diagnoses: Hemiplegia and Hemiparesis , Alzheimer's Disease MDS (Minimum Data Set) assessment: 08/28/23 - Quarterly Sec. (Section) C : BIMS (Brief Interview for Mental Status)= Cannot Obtain (Cognitive Impairment) Sec. G: Total Care with ADL's (Activities of Daily Living) Resident #20: (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date of Admission: 10/03/23 Diagnoses: Schizophrenia, Dementia, MDS: 07/07/23 - Quarterly Sec C: BIMS= 04 (Cognitive Impairment) Sec G: Total Dependence with ADL care Resident #72: Date of Admission: 01/04/22 (Current Hospice) Diagnoses: Dementia, Alzheimer's Disease MDS: 08/09/23 - Quarterly Sec C: BIMS = Unable To Obtain (Cognitive Impairment) Sec G: Total Dependence with ADL Care