

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105335	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Abbey Delray		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 SW 11th Court Delray Beach, FL 33445	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39142</p> <p>Based on interviews, record reviews and observations, the facility failed to protect the residents' right to be free from neglect when it failed to provide the required structures and processes to maintain and secure the exit doors to meet the needs of residents, for 1 of 1 sampled resident (Resident #1).</p> <p>The deficient practice allowed Resident #1 to leave the facility through an unlocked exit door on 09/12/24 between 4:00 AM and 5:00 AM. Resident #1 wheeled himself in his wheelchair to the facility's loading dock, where he fell and was seriously injured. Resident #1 was transferred to the hospital.</p> <p>There were eighty-nine residents in the facility at the time of the survey. The facility's administrator was notified of Immediate Jeopardy and was given the Immediate Jeopardy Templates on 12/05/24 at 6:22 PM.</p> <p>The Immediate Jeopardy was removed at the time of the facility exit on 12/06/24.</p> <p>Cross reference to F689.</p> <p>The findings included:</p> <p>The facility's policy titled Abuse, Neglect, and Exploitation, Revision date: 09/20/24 defines Neglect as follows: Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>Resident #1 admitted to the facility on [DATE]. Resident #1 had the diagnoses that included but were not limited to the following: Malignant Neoplasm (cancer) of the Prostate, Anemia (a low number of red blood cells that can affect oxygen supply), Gastrointestinal Hemorrhage (bleeding), Acute Respiratory Failure (a condition in which there is not enough oxygen or too much carbon dioxide in the body), Hypertension (high blood pressure), Adult Failure to Thrive (a state of decline in physical and functional abilities, leading to a decrease in overall well-being), and Physical Debility (weakness caused by an illness, injury, or aging).</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 105335	If continuation sheet Page 1 of 11

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident #1 had his comprehensive assessment completed on 08/26/2024. Resident #1 was admitted to the facility after being hospitalized for Gastrointestinal Hemorrhage. At the time of the comprehensive assessment, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14/15. This means he was cognitively intact.</p> <p>According to the facility's investigation of the incident on 09/12/24 between 4:00 AM and 5:00 AM, Resident #1 left through the exit door on the north side of the facility, near his room. The resident subsequently wheeled himself to the facility's loading dock where he had a fall with serious injuries. This exit door had a door release bar and was labeled with the following instructions: Push Until the Alarm Sounds; The door can be opened in 15 seconds. The Root Cause Analysis, done by the facility on 09/12/24 revealed the door's alarm and magnetic lock had been deactivated, which allowed the door to be opened without the alarm sounding. Resident #1 exited undetected from this door.</p> <p>Review of the hospital records revealed Resident #1's fall on 09/12/24 resulted in Type II and Type III fractures of the second cervical (neck) vertebra (a small bone that is part of the backbone) (C2) and fractures of the first cervical vertebra (C1). The radiology report indicated that the results were critical.</p> <p>On 12/02/24 at 2:24 PM, a telephone interview was conducted with Staff A, a Registered Nurse (RN), who was Resident #1's assigned nurse at the time of the incident. Staff A explained that when she went out the same door Resident # 1 used, she noted the door opened easily without an alarm sounding.</p> <p>On 12/02/24 at 3:00 PM, A telephone Interview with Staff B, a Certified Nursing Assistant. Staff B stated that she did not hear any alarms when Resident #1 left the building. Staff B stated that Resident #1 was in bed when she checked on him early in her shift between 11:00 PM and 12:00 AM. She stated he complained he was cold, and she helped him put on clothing and offered him an extra blanket. Staff B stated she did not remember if the resident was able to transfer himself to the wheelchair. Staff B stated that during the search for Resident #1 she tried the door at the end of the 400-hallway and it just opened without the alarm sounding.</p> <p>On 12/02/24 at 4:00 PM, an interview was conducted with Staff C, a CNA. Staff C explained that she was not assigned to Resident #1, but she was the CNA who found Resident #1. Staff C showed the surveyor exactly where Resident #1 was found outside. The CNA explained that she moved the wheelchair off Resident #1 and called the nurse to tell the nurse where Resident #1 was found. Staff C stated she found Resident #1 because he was calling out to send someone to help him. Staff C stated Resident #1 didn't want anyone to move him except for the ambulance people.</p> <p>On 12/05/24 at 3:21 PM, an interview was with Staff D, Maintenance Technician. Staff D stated he checks the doors at 8:00 AM every day he works, which is Tuesday through Saturday, he checks all the exits in the building by pushing on the release bar for 15 seconds. He stated the alarm sounds if it is working correctly. The maintenance technician provided documentation that he was working on 9/12/24. Staff D stated the door was working on 09/12/24 when he checked the door at 8:00 AM, which was after the incident had occurred.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 12/05/24 at 3:53 PM a telephone interview was conducted with the former administrator who worked for the facility at the time of the elopement. The former administrator stated he was on site at approximately 6:30 AM on 09/12/24. He stated he was able to reactivate the key code for the door which put the door back in service and activated the alarm. The former administrator stated he had a conversation with the vendor of the company that placed the key code pads to override the door locks. The vendor explained the door had been in maintenance mode, which deactivated the alarm and magnetic lock.</p> <p>On 12/05/24 at 3:25 PM, the Director of Plant Operations (DPO) explained that the facility provides key codes to staff because the dietary, housekeeping, and maintenance staff need to travel from the facility to the adjacent building where the kitchen, housekeeping and maintenance departments are located. The DPO provided a repair document that showed the key code for the door was changed on 09/12/24, the day of the incident.</p> <p>On 12/05/2024 at 4:28 PM, an interview was conducted with Staff E, Dietary Assistant. When asked if she knew the code to go to the kitchen she said yes, it's [code number], which is the correct code as provided by the DPO. Staff E stated she started working for the facility on August 14, 2024. She stated that since she started that was the only code she was given.</p> <p>On 12/05/2024 at 4:36 PM, an interview was conducted with Staff F, Dietary Assistant. Stated she has been working for the facility for 9 months. She stated she only has one code for the 4-North door, [code number]. At that time the surveyor accompanied Staff F to the 4-North door for a demonstration of how the door worked when functioning correctly. Staff F entered the code and pressed the door open button. The door swung open with the alarm sounding. Staff F stated the alarm sounded until the door fully closed. This was witnessed to be true. The surveyor attempted to use a four-digit code as had been described by the DPO and the former administrator. The code did not unlock the door or allow it to open when the door open button was pressed.</p> <p>On 12/06/2024 at 10:54 AM, an interview was conducted with Staff G, a housekeeper, regarding the 4-North door key code and using the 4-North door. Staff G stated she has been working for the facility for [AGE] years. She stated she uses the 4-North door approximately 4 times a day. Staff G stated she uses the door if she needs to see the supervisor, for daily huddles (meetings), to get housekeeping supplies and occasionally to bring resident laundry to the laundry room. Staff G stated she primarily does room cleaning. Staff G stated she works from 7:30 AM until 3:30 PM.</p> <p>On 12/06/24 at 11:13 AM, an interview was conducted with Staff H, Custodian. Staff H stated he has worked for the facility for 8 years. Staff H stated he uses the 4-North door more than 5 times a day. He stated he transports laundry, trash, and equipment using that door. He stated that after the incident the staff were trained to make sure there were no residents following them out the door and to make sure the door was closed fully before leaving the area. Staff H stated he works from 6:00 AM to 2:00 PM daily.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 12/06/24 at 4:46 PM, an interview was conducted with Staff I, who works for the facility as a maintenance worker and in a second capacity on the weekends as a Security Guard. He confirmed the hours have changed to arm [turn on] the screamer alarm, which is the loud alarm added to the 4-North door after the elopement. The Security Guard stated the screamer alarm is now armed at 8:00 PM instead of 11:00 PM. Staff I confirmed that this was a change made as of 12/06/24. Staff I confirmed that he patrols the facility and tests all the doors to ensure they remain locked. Staff I stated he checks the doors often as he patrols.</p> <p>*The facility submitted an acceptable Immediate Jeopardy Plan on 12/06/2024, the surveyor verified the implementation of the following immediate actions in the Immediate Jeopardy Removal Plan:</p> <ol style="list-style-type: none"> 1. Resident #1 was no longer a resident in the facility. 2. From 12/05/24 to 12/6/24, Johnson Controls, the company that installs and maintains the key code pad, cleared all historical code system data and recoded doors for safety and security. <p>On 12/05/24 Johnson Controls changed maintenance code access. The community will not have access to the maintenance code.</p> <ol style="list-style-type: none"> 3. On 12/05/24 Security will round on the Health Center and activate multi-functional door alarm on Poinciana North from 8 p.m. to 7 a.m. daily. 4. On 12/5/24 the Executive Director completed one to one education with Director of Plant Operations, Interim NHA, and Director of Nursing on the expectation that maintenance will check exit doors throughout the Health Center for security and functioning daily. 5. On 12/06/24, the NHA, who is also the Abuse coordinator, and Director of Plant Operations began the education of Health Center maintenance team members and administration team members on the neglect policy. Health center maintenance team members will not be allowed to work until education is completed. There are 9 of 9 health center maintenance team members who have completed the neglect training. There are currently 11 administrative team members of which 10 have completed the neglect training and 1 is out on PTO [Paid Time Off] and will be educated upon return. <p>**On 12/06/2024 the surveyor collected and verified the following removal plan immediate actions:</p> <ol style="list-style-type: none"> 1. During interviews with kitchen staff on 12/05/24 and 12/06/24, the surveyor and a kitchen staff employee went to the door to try the code needed to open the door. After the employee successfully operated the door, the surveyor performed a test by putting in the proper code first. After the proper code was used the surveyor attempted to imitate the use of a fourth digit as a repeat of the third digit. The door failed to open as the code was rejected. The keypad had lights on the keypad display to determine if the correct code was entered. The light changed to green for the correct code and flashed yellow for the incorrect code. When the door successfully opened; the alarm sounded continuously until the door closed. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39142</p> <p>Based on interviews, record review and observations, the facility failed to provide supervision and a secure environment to prevent 1 of 1 sampled resident (Resident #1), from exiting the safety of the facility and subsequently experiencing a fall with serious injuries.</p> <p>The deficient practice occurred on 9/12/24 between 4:00 AM and 5:00 AM. While in his wheelchair, Resident #1, exited out an unlocked exit door at the end of the 400-Hallway, on the north side of the facility. Resident #1 then wheeled himself down a concrete walkway to the loading dock where there was a set of three steps. Resident #1 fell down the steps with his wheelchair where he suffered serious injuries to his cervical (neck) spine (vertebrae). Resident #1 was transferred to the hospital via ambulance.</p> <p>There were eighty-nine residents in the facility at the time of the survey. The facility's Administrator was notified of Immediate Jeopardy and was given the Immediate Jeopardy Templates on 12/05/24 at 6:22 PM.</p> <p>The Immediate Jeopardy was removed by the time of the facility exit on 12/06/24.</p> <p>Cross reference to F600.</p> <p>The findings included:</p> <p>The facility's policy titled Elopement, Unsupervised Absence, Hazardous Wandering and Missing Residents, revised 11/07/24 defines a Missing Resident as follows: A resident is considered missing when they are absent from the place where they ought to be and their whereabouts is unknown.</p> <p>Resident #1 was admitted to the facility on [DATE] after being hospitalized for Gastrointestinal Hemorrhage. Resident #1 had the diagnoses that included but were not limited to the following: Malignant Neoplasm (cancer) of the Prostate, Anemia (a low number of red blood cells that can affect oxygen supply), Gastrointestinal Hemorrhage (bleeding), Acute Respiratory Failure (a condition in which there is not enough oxygen or too much carbon dioxide in the body), Hypertension (high blood pressure), Adult Failure to Thrive (a state of decline in physical and functional abilities, leading to a decrease in overall well-being), and Physical Debility (weakness caused by an illness, injury, or aging).</p> <p>Resident #1 had his comprehensive assessment completed on 08/26/2024. At the time of the comprehensive assessment, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14/15. This means he was cognitively intact.</p> <p>According to the facility's investigation of the incident, on 09/12/24 at between 4:00 AM and 5:00 AM, Resident #1 went out of the exit door on the north side of the facility, near his room, which was at the end of the 400-hallway closest to the exit used.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The Root Cause Analysis, completed by the facility on 09/12/24, revealed the exit door's alarm and magnetic lock had been deactivated, which allowed the door to be opened without the alarm sounding. Resident #1 exited undetected from this door. Resident #1 subsequently propelled himself in his wheelchair down a concrete walkway to the right of the exit, to the loading dock area, to a set of 3 steps that are part of the loading dock. Resident # 1 was found at the bottom of the steps with his wheelchair on top of him.</p> <p>On 12/02/24 at 10:15 AM, a tour of the exit route was taken accompanied by the Director of Plant Operations (DPO). The DPO provided measurements of the 3 steps where Resident #1 went down. The height of the stairs is approximately 16 inches and the distance from the front edge of the top step to the base at the bottom step is approximately 23 inches.</p> <p>On 12/03/24 at 4:42PM, a review of the hospital records revealed Resident #1's fall on 09/12/24 resulted in Type II and Type III fractures of the second cervical (neck) vertebra (a small bone that is a part of the backbone) (C2) and acute fractures to the left and posterior ring of the first cervical vertebra (C1). The radiology report indicated that the results were critical. Resident #1 was admitted to the hospital's trauma unit on 09/12/24.</p> <p>On 12/02/24 at 3:00 PM, an interview was conducted with Staff B, the CNA assigned to Resident #1 on the 11:00 PM to 7:00 AM shift which spanned from 09/11/24 to 9/12/24. Staff B stated she last saw Resident #1 at approximately 3:00 AM. Staff B stated that when she went to Resident #1's room at approximately 4:20 AM, on 09/12/24, to start morning care, she noticed he was missing. Staff B stated that Resident #1 was awake earlier and complained of being cold, Staff B stated she assisted Resident #1 to put on warmer clothes and offered him a blanket. Staff B stated she did not hear the door alarm sounding at the time Resident #1 was found missing. Staff B reported she informed Staff A, the nurse assigned to Resident #1, immediately upon finding Resident #1 missing. Staff B stated that when she checked the door at the end of the 400-hallway, where Resident #1 left, she found it to be unlocked and easily opened without the alarm sounding.</p> <p>On 12/02/24 at 2:24 PM, an interview was conducted with Staff A, the nurse assigned to Resident #1. Staff A stated that a search was conducted for Resident #1 when Staff B reported him missing. Staff A stated that when he was found she had been told, by the CNA who found him, that Resident #1 was found with his wheelchair on top of him. Staff A stated Resident #1 had blood on his face and an open cut on his left arm. Staff A reported Resident #1 shouted he did not want anyone to touch him until the ambulance arrived. Staff A stated Resident #1 did not want to answer any questions regarding the incident.</p> <p>On 12/02/24 at 4:00 PM an interview was conducted with Staff C, a CNA. Staff C stated she was not assigned to care for Resident #1, but she was the one who found him. Staff C stated she found Resident #1 at the bottom of the stairs that are part of the loading dock. Staff C stated Resident #1 was calling for someone to help him. Staff C stated she found Resident #1 at the bottom of the stairs with the wheelchair on top of him. Staff C stated Resident #1 did not want to be touched until the ambulance people got there and would not tell anyone what happened.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 12/05/24 at 3:53 PM an interview was conducted with the former Administrator, who was the Administrator of record at the time of the incident. According to the former Administrator, he arrived at the facility by 6:30 AM on 09/12/24. The former Administrator stated he found the 400-hallway door unlocked when he arrived and reset the key code at that time. The former Administrator stated he discussed the situation with the vendor who explained that the door had been in maintenance mode and that was why the door was unlocked with the alarm off.</p> <p>On 12/05/24 at 3:25 PM, the Director of Plant Operations (DPO) explained that the facility provides key codes to staff because the kitchen, housekeeping, and maintenance staff need to travel from the facility to the adjacent building where the kitchen, housekeeping and maintenance departments are located. The DPO provided a repair document that showed the key code for the door was changed to prevent employees from accidentally entering the maintenance code to deactivate the door. This change was made on 09/12/24, the day of the incident. The DPO stated the vendor explained the code to unlock the door and disarm the alarm to put the door into 'maintenance mode' was like the code provided to the employees.</p> <p>On 12/05/2024 at 4:28 PM, an interview was conducted with Staff E, Dietary Assistant. When asked if she knew the code to go to the kitchen, she replied yes, it's [code number], which is the correct code as provided by the DPO. Staff E stated she started working for the facility on August 14, 2024. She stated that since she started that was the only code she was given.</p> <p>On 12/05/2024 at 4:36 PM, an interview was conducted with Staff F, Dietary Assistant. Stated she has been working for the facility for 9 months. She stated she only has one code for the 400-Hallway exit door, [code number]. At that time, the surveyor accompanied Staff F to the 4-N door for a demonstration of how the door worked when functioning correctly. Staff F entered the code and pressed the door open button. The door swung open with the alarm sounding. Staff F stated the alarm sounded until the door fully closed. This was witnessed to be true. The surveyor attempted to use a four-digit code as had been described by the DPO and the former Administrator. The code did not unlock the door or allow it to open when the door open button was pressed.</p> <p>On 12/06/24 at 10:54 AM, an interview was conducted with Staff G, a housekeeper, regarding the 400-Hallway exit door key code and using this exit door. Staff G stated she has been working for the facility for [AGE] years. She stated she uses this exit door approximately 4 times a day. Staff G stated she uses the door if she needs to see the supervisor, for daily huddles (meetings), to get housekeeping supplies and occasionally to bring resident laundry to the laundry room. Staff G stated she primarily does room cleaning and she works from 7:30 AM until 3:30 PM. Staff G stated she has seen the maintenance department checking the doors several times a day since the incident.</p> <p>On 12/06/24 at 11:13 AM, an interview was conducted with Staff H, Custodian. Staff H stated he has worked for the facility for 8 years. Staff H stated he uses the 4-north door more than 5 times a day. He stated he transports laundry, trash, and equipment using that door. He stated that after the incident the staff were trained to make sure there were no residents following them out the door and to make sure the door was closed fully before leaving the area. Staff H stated he has witnessed maintenance staff check the doors in the morning. He stated he was unsure if he has seen maintenance checking the doors other times. Staff H stated he works from 6:00 AM to 2:00 PM daily.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 12/06/24 at 4:46 PM, an interview was conducted with Staff I, who works for the facility as a maintenance worker and in a second capacity on the weekends as a Security Guard. He confirmed the hours have changed to arm [turn on] the screamer alarm, the loud alarm added to the 4-North door after the elopement, at 8:00 PM instead of 11:00 PM previously scheduled. Staff I confirmed that this was a change made as of 12/06/24. Staff I confirmed that he patrols the facility and tests all the doors to ensure they remain locked. Staff I stated he checks the doors often as he patrols.</p> <p>*The facility submitted an acceptable Immediate Jeopardy Removal Plan and on 12/06/2024, the surveyor verified the implementation of the following immediate actions in the Immediate Jeopardy removal plan:</p> <ol style="list-style-type: none"> 1. Resident #1, who was not determined to be an elopement risk, was no longer a resident in the community. 2. From 12/05/24 to 12/06/24, Johnson Controls, the company that installs and maintains the key code pad, cleared all historical code system data and recoded doors for safety and security. 3. On 9/12/24 Johnson Controls changed maintenance code access. The community (employees and security guards) will not have access to the maintenance code. 4. Starting on 12/05/24 Security will round on the Health Center and activate the screamer loud alarm on Poinciana North from 8pm to 7am daily. 5. On 12/05/24 the Executive Director completed one on one education with Director of Plant Operations, Interim NHA, and Director of Nursing on the expectation that maintenance will check exit doors throughout the Health Center for security and functioning daily. 6. On 12/06/24, the NHA, who is also the Abuse coordinator and Director of Plant Operations, began education of Health center maintenance team members and administration team members on the missing person policy and exit door and alarm checks. Health center maintenance team members will not be allowed to work until education is completed. There were 9 of 9 health center maintenance team members who had completed this training. There are currently 11 administrative team members, of which 10 have completed this training and 1 is out on PTO (Paid Time Off) and will be educated upon return. <p>**On 12/06/24 the surveyor collected and verified the following removal plan immediate actions:</p> <ol style="list-style-type: none"> 1. During interviews on 12/05/24 and 12/06/24, with kitchen staff, the surveyor and a kitchen staff employee went to the door to try the code needed to open the door. After the employee successfully operated the door, the surveyor performed a test by putting in the proper code first. After the proper code was used, the surveyor attempted to use a four-digit code to place the door in maintenance mode. This attempt with the four-digit code failed as expected. 2. An interview on 12/6/24 at 4:46 p.m. with the Security Guard on duty revealed the facility changed the alarm check routine and the activation time for the loud alarm that was added after the incident. The Security Guard confirmed the loud alarm would be activated at 8:00 PM every night and it would be deactivated at 7:00 AM every morning. The Security Guard confirmed all the doors would be checked for security and alarms sounding at various intervals throughout the night. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105335	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Abbey Delray		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 SW 11th Court Delray Beach, FL 33445	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>3. The facility provided electronic evidence of staff education on Missing person and door/alarm checks and with written records. There were 109 out of 112 employees educated as of 12/06/24, when the spreadsheet was completed. This equals 97%.</p> <p>4. The facility provided evidence of education of the Director of Plant Operations, Interim NHA, and Director of Nursing on the expectation that maintenance will check exit doors throughout the Health Center for security and functioning daily.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105335	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>39142</p> <p>Based on interview, record review, and observation the facility failed to provide appropriate Perineal Care to prevent Urinary Tract Infections (UTIs) for 1 of 1 resident observed for Perineal care (Resident #2).</p> <p>Findings included:</p> <p>The facility's policy titled Perineal Care, date February 2018, included: For a female resident .it states Wash perineal area, wiping from front to back. Subitem (1) documented Separate the labia and wash area downward from front to back. Subitem (2) documented Continue to wash the perineum moving from inside outward to the thighs. Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth.</p> <p>On 12/03/24 at 10:00 AM an observation was made of Perineal Care for Resident #2. At the time of the observation, Infection Notes documented that Resident #2 was being treated for a Urinary Tract Infection.</p> <p>The observation was as follows:</p> <p>The Certified Nursing Assistant (CNA) provided dignity and privacy to the resident by closing the door and drawing the curtains. The CNA placed her supplies, which were in a plastic bag, on the overbed table. The CNA failed to disinfect the surface of the table before starting. The CNA provided the resident with a bath towel to cover her perineum for privacy and dignity. The CNA used proper technique to remove the peri pad and incontinent brief from the resident and placed a towel under the resident to protect the bed linens from contamination. The CNA removed her gloves, washed her hands and put on clean gloves. The CNA proceeded to put soap on a wet washcloth to clean the resident. The CNA started from the inner thighs and moved inward. The CNA washed the inner right thigh first. The CNA washed the resident's thigh in an upward motion from back to front. The CNA continued to wash in toward the right outer labia. The CNA then proceeded to wash the inner left thigh from back to front and in toward the left outer labia. The CNA washed the left labia upward from back to front, proceeding to the inner folds of the left labia. The CNA repeated this way with the right labia. The CNA then used a clean washcloth wet from the basin to rinse the resident's perinium. The CNA removed her gloves, washed her hands and put on clean gloves. The CNA assisted Resident #2 onto her left side and proceeded to wash the resident's posterior without any further concerns.</p> <p>On 12/03/24 at approximately 10:45 AM the surveyor interviewed the Director of Nursing (DON) regarding the observation of the perineal care. The DON agreed that the CNA did not use proper technique for perineal care. The DON stated the CNA would be re-educated immediately.</p>		