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	09/05/2025

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

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, record and policy review, the facility failed to protect the resident's right to be free from neglect by failing to provide necessary supervision to prevent the likelihood of serious injury, harm, impairment, or death by allowing an elopement for 1 of 3 sampled residents (Resident #1) reviewed for an elopement. The facility failed to ensure effective measures were in place to prevent the elopement in both the secured unit and the exit from the building.The deficient practice allowed Resident #1 to exit the facility undetected on 08/30/25 at 4:23 PM. There were 182 residents in the facility at the time of the survey. The facility's Administrator was notified of Immediate Jeopardy and given the IJ Template on 09/04/25 at 3:05 PM. The immediate jeopardy was removed on 09/04/25 at 4:45 PM, and the deficiency was lowered to a scope and severity of D, isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Cross reference to F689.The findings included: A review of the facility's policy titled Abuse and Neglect, reviewed 11/19/24, documented: To minimize the threat of abuse and or neglect, nursing homes must incorporate clear cut policies and practices that demonstrate a hard line, 0 tolerance approach to resident abuse. Each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation of any type by anyone. How: The facility has procedures in place to provide protection for the health, welfare and rights of each resident residing in the facility. In order to provide these protections, the facility has implemented procedures to prohibit and prevent abuse, neglect, exploitation of residents, and misappropriation of resident property. These procedures include but are not limited to the following.2). Training, 3). Prevention, 4). Identification.6). Protection.Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease, General Muscle Weakness, Dysphagia, Cognitive Communication Deficit, Major Depressive Disorders, Altered Mental Status, Epilepsy, Alcohol Abuse, and Blindness of the Right Eye.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11, on a 0 to 15 scale, indicating the resident had moderate cognitive impairment. This same MDS indicated that Resident #1 was able to ambulate without any assistive devices with supervision and touching assistance. A BIMS score conducted on 09/01/2025 revealed a score of 5 indicating the resident had severe cognitive impairment. An Elopement risk evaluation conducted on 08/06/2025 indicated the resident was at risk for Elopement. Review of the clinical census revealed Resident #1 had been in the facility's secured unit (west wing) since her admission date. (A secured unit is a designated area within a facility that offers enhanced security and supervision for residents who may be prone to wandering or require specialized care. These units are specifically designed to meet the unique needs of individuals with memory-related disorders, ensuring their safety and well-being.)Review of Resident #1's care plan initiated on 08/03/25 documented, At risk for elopement . Goal: The resident will not leave facility unattended through the review date with an intervention that documented, Provide for safe wandering - resident is an elopement risk.Review of the active orders dated 08/09/25 documented, Exit seeking. Provide safe wandering, resident is at risk for elopement. every shift.The video of the elopement incident, involving Resident #1 was viewed by the surveyor on 09/03/25 at 1:36 PM. The following was noted: On 08/30/25 at 4:23 PM the receptionist was attending to two visitors in the main lobby by the entrance of the facility. These two visitors blocked the view of the receptionist who was sitting down at that moment and Resident #1 walked behind the two visitors and walked out towards the door. During this same time at 4:23 PM, another visitor is buzzed in by the receptionist Resident #1 walked out quickly as the visitor walked in. (This door remains locked and must manually be unlocked by an individual after engaging a buzzer to enter the facility). The receptionist did not notice Resident #1 had exited the facility unaccompanied, via the main entrance camera in front of her, which she was responsible for monitoring. The resident was observed to be wearing a red T-shirt, red leggings with a pattern and black tennis shoes. She was seen walking in a fast and steady manner with no assistive devices at the time of exit. In the surveillance footage, there were no additional staff present at the main entrance at time of the resident's exit.Resident #1's room was located on the west side of the facility in a locked unit. Two hallways lead to the west unit (C and D unit) both unsecured. A middle hallway (center core) joins the C and D unit on the west side; this same hallway's east side leads to two additional units (A and B units) which lead to the East Unit on the opposite side of the building. The middle hallway leads to the main lobby and facility's main entrance An interview with the administration team was conducted on 09/03/25

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, record and policy review, the facility failed to provide necessary supervision to prevent the likelihood of serious injury, harm, impairment, or death by allowing an elopement for 1 of 3 sampled residents (Resident #1) reviewed for an elopement. The facility failed to ensure effective measures were in place to prevent the elopement in both the secured unit and the exit from the building.The deficient practice allowed Resident #1 to exit the facility undetected on 08/30/25 at 4:23 PM. There were 182 residents in the facility at the time of the survey. The facility's Administrator was notified of Immediate Jeopardy and given the IJ Template on 09/04/25 at 3:05 PM. The immediate jeopardy was removed on 09/04/25 at 4:45 PM and the deficiency was lowered to a scope and severity of D, isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Cross reference to F600.The findings included:A review of the facility's policy titled, Missing Residents/Actual Elopement, review date 03/27/25, documented: Definition of elopement, this occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. Situation in which a resident with decision, making capacity leaves the facility intentionally but generally not be considered an elopement unless the facility is unaware of the resident's departure and/or whereabouts. The Executive Director or designee will report the event to all appropriate agencies as well as the regional divisional team. The event will be reviewed in an ad-hoc QAPI meeting, to determine how to ensure that a plan and system is in place to mitigate another occurrence.Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease, General Muscle Weakness, Dysphagia, Cognitive Communication Deficit, Major Depressive Disorders, Altered Mental Status, Epilepsy, Alcohol Abuse, and Blindness of the Right Eye. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11, on a 0 to 15 scale, indicating the resident had moderate cognitive impairment. This same MDS indicated that Resident #1 was able to ambulate without any assistive devices with supervision and touching assistance. A BIMS score conducted on 09/01/2025 revealed a score of 5 indicating the resident had severe cognitive impairment. 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Provide safe wandering, resident is at risk for elopement. every shift.The video of the elopement incident, involving Resident #1 was viewed by the surveyor on 09/03/25 at 1:36 PM. The following was noted: On 08/30/25 at 4:23 PM the receptionist was attending to two visitors in the main lobby by the entrance of the facility. These two visitors blocked the view of the receptionist who was sitting down at that moment and Resident #1 walked behind the two visitors and walked out towards the door. During this same time at 4:23 PM, another visitor is buzzed in by the receptionist Resident #1 walked out quickly as the visitor walked in. (This door remains locked and must manually be unlocked by an individual after engaging a buzzer to enter the facility). The receptionist did not notice Resident #1 had exited the facility unaccompanied, via the main entrance camera in front of her, which she was responsible for monitoring. 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