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	02/24/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to promote healing of a facility acquired pressure ulcer for 1 of 3 sampled residents (Resident #1).The findings included: Record review revealed Resident #1 was initially admitted to the facility on [DATE], with multiple readmissions, with a diagnosis that included Dementia. A review of a comprehensive assessment dated [DATE] documented that the resident had severe cognitive impairment and required total assistance with all activities of daily living. The assessment further documented Resident #1 had weight loss, two stage 3 pressure ulcers and was always incontinent of bladder and bowel.Record review revealed Resident #1 was care planned for at risk for break in skin integrity, dated 10/22/19. Interventions included clean and dry skin after each incontinent episode, turn and reposition frequently, and a low air loss mattress.Record review revealed Resident #1 was care planned for a left buttock and sacral pressure ulcer, dated 01/11/26. Interventions included to administer treatments as ordered, and frequent incontinent care, and strive to keep skin clean and dry.Record review revealed a progress note dated 01/11/26 that documented Resident #1 had wounds to the left buttock and sacrum identified by a certified nurse assistant (CNA).Record review revealed wound care notes documented Resident #1 was seen by wound care on 01/13/26 and the wounds were a stage 3.A review of Resident #1's physician orders revealed an order dated 01/15/26 for wound care to be done daily and as needed (if dressings are soiled, wet, or fall off). A review of Resident #1's Medication Administration Record (MAR) revealed wound care was not done on 01/16/26 and there was no documentation of why the wound care was not completedRecord review revealed Resident #1 was seen for wound care on 01/21/26. The left buttock wound had resolved. The sacral wound had deteriorated. The wound care/dressing changes were changed to twice daily. A review of Resident #1's MAR revealed wound care was not done on 01/22/26 evening, and there was no reason given. Record review revealed orders for a sacral wound culture were received and done on 01/27/26. Resident #1 was seen by wound care on 01/28/26. The resident's sacral wound had deteriorated to a stage 4 pressure ulcer. Wound care orders were changed but continued at twice a day. Further record review revealed on 01/31/26, Resident #1's sacral wound culture came back positive for 3 different bacteria, and the resident was started on intravenous (IV) antibiotics. A sacral x-ray was ordered and completed on 02/02/26 which indicated Resident #1 had osteomyelitis (bone infection). Resident #1 started on IV Vancomycin on 02/03/26. Record review revealed Resident #1 was seen by wound care on 02/04/26 and the sacral wound was unchanged. Since the resident had just started on IV antibiotics, the plan was to send the resident to the hospital in a week if the sacral wound did not improve. Record review revealed Resident #1 was sent out to the hospital on [DATE] for a feeding tube placement. The resident returned to the facility on [DATE].An interview was conducted with the wound care nurse (WCN) on 02/24/26 at 1:00 PM. The WCN confirmed Resident #1's left buttock and sacral wounds were first identified as stage 3 pressure ulcers. The left buttock wound resolved, but the sacral wound deteriorated.

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