Printed: 06/05/2026
Form Approved OMB
No. 0938-0391

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	03/18/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an effective infection prevention and control program to help prevent the development and transmission of the communicable disease scabies, as evidenced by the failure to ensure documented evidence of the provision of ivermectin, a medication to treat scabies, and ensure dermatological appointment for Resident #1; failure to initiate timely contact precautions for 3 of 11 sampled residents (Residents #8, #5, and #2); failure to ensure an effective Infection Control Surveillance plan as evidenced by the failure to log 7 of 10 sampled residents who presented with a rash and were reported to the State Agency in October 2025 (Residents #1, #7, #9, #10, #11, #12, and #13), and 2 of 2 sampled residents in November 2025 (Residents #2 and # 8); failure to ensure appropriate housekeeping and laundry services for residents affected with and or treated for scabies for 1 of 6 units affected (West Unit); and failure to ensure staff education in November 2025 during a potential scabies outbreak.The findings included:1) Review of the record revealed Resident #1 was admitted to the facility on [DATE]. Review of the weekly skin assessments from 12/01/25 through 02/02/26 all documented the resident had a rash.a) Review of physician orders revealed an order dated 12/30/25 to administer ivermectin on 12/31/25 and 01/14/26 for scabies. A progress note dated 01/01/26 documented a nurse contacted the pharmacy regarding the ivermectin and the pharmacy stated it would be sent again on the 5 PM run that same day. The record lacked any evidence of the provision of the medication.b) A progress note dated 01/05/26 documented the resident was to be added to the dermatology consultants list to be seen at the next visit. A subsequent physician order dated 01/28/26 documented a dermatological consultation for a rash on the resident's back and upper arms. The record lacked any evidence of the provision of this consultation.During a side-by-side record review and interview on 03/18/26 at 10:54 AM the Infection Control Preventionist (ICP) agreed with the findings. 2) Review of the policy titled Care of the Resident with Scabies revised 05/13/23, documented in part, that residents with scabies should be placed on contact precautions prior to and during the treatment period.a) Review of the record revealed Resident #8 was treated for scabies as per physician order for permethrin cream on 11/12/25, 11/19/25, 12/13/25, 12/20/25, 12/31/25, and 01/07/26. Resident #8 was also administered ivermectin as per physician order on 12/13/25, 12/20/25, 12/31/25, and 01/14/26.Further review of the record revealed appropriate contact precautions from 11/12/25 through 11/20/25, but lacked further contact precautions until 12/31/25, eight-teen days after continued treatment.b) Review of the record revealed Resident #5 was treated with permethrin cream as per physician order on 07/18/25, 07/25/25, and 01/26/26. Resident #5 received ivermectin as per physician order on 02/07/26 and 02/21/26. The record lacked any evidence of contact precautions during the treatment.c) Review of the record revealed Resident #2 was admitted to the facility on [DATE].Review of the record revealed Resident #2 was treated with permethrin as per physician order on 01/11/26, 01/15/26, 01/22/26, 03/15/26 and 03/16/26. Resident #2 was also administered ivermectin as per physician order on 12/13/25 01/11/26, 01/15/26, 01/22/26, and 03/14/26.Further review of the record documented contact precautions were ordered from 12/06/25 - 12/22/25, 01/15/26 through 01/24/26, four days after initiation of treatment, and then not initiated until the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105516	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER: Darcy Hall of Life Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evening shift on 03/16/26, two days after initiation of treatment.During an interview on 03/17/26 at 12:50 PM, when asked about the care and services at the facility, Resident #2 stated everything was okay except for the rash that he got at the facility. The resident stated he has been treated on an off for a few months.During an interview on 03/18/26 at 11:17 AM, when asked about the initiation of contact precautions for scabies, the ICP confirmed they would start the precautions with suspicion and or treatment for scabies. The ICP stated their onsite dermatologist would sometimes order treatment directly from the pharmacy and they would all of the sudden receive tubes of the permethrin cream, without having previous knowledge of the pending treatment. 3) During an interview on 03/18/26 at approximately 11:30 AM, the ICP was asked to locate and provide evidence of notification to the State Agency of their rash/scabies outbreak. Review of the provided log documented ten residents who presented with an itchy rash as of 10/16/25 and two additional residents who presented with an itchy rash on 11/17/25.Review of the corresponding Infection Surveillance Line Listing Report revealed seven of the ten residents in October 2025, including Residents #1, #7, #9, #10, #11, #12, and #13, were not included in the facility's surveillance log. The two residents in November 2025, Residents #2 and # 8, were also not included in the facility's surveillance log.During an interview on 03/18/26 in the afternoon, upon discussion of the facility's Infection Surveillance Line Listing Report and the report sent to the State Agency, the ICP explained the State Agency only wanted a line listing of those residents with a rash and or symptoms like itching. When told not all of the residents on the State Agency report were included in the facility's surveillance log, the ICP had no explanation but agreed the log was used to track and trend infections. 4) Review of the policy Care of the Resident with Scabies revised 05/13/23, documented in part, the facility should place any bed linens, towels, washcloths, or lift slings present in the room, along with any clothing that had been worn in the preceding 3 days, in a plastic bag that could be sealed through tying or taping. The policy then described specifically how the items should be laundered or maintained to eliminate the scabies. This policy further documented mattresses should be thoroughly vacuumed.During three interviews on 03/18/26 in the afternoon, when asked the environmental process when a resident was being treated for scabies, the Director of Environmental Services explained he and his staff would remove all the linens, curtains, and personal belongings and put them in a red bag. He further described the subsequent washing process. The director finally stated the room would need to be cleaned from top to bottom. When asked if there was documentation of their process for the recent November 2025 outbreak the director stated he would provide it.The director returned with documented evidence of Routine Cleaning Schedule for November 2025. These documents lacked any evidence of a thorough or deep cleaning, or any documented evidence linens or personal belongings were treated. The director then stated he would bring another form they utilize.Review of the second forms provided titled, Terminal Cleaning Checklist included six pages, dated 11/13/25 through 11/18/25, with the first page only documenting the [NAME] Unit, which was the unit affected by the scabies, and the other forms not documenting any unit. The forms also lacked any room numbers in the area to document same. These forms were initialed by the director and contained checkmarks down the list of to do items. This list documented staff where to remove facility provided linens for laundering. This list lacked any documentation related to the bagging of linens and personal items, or the thorough vacuuming of the mattress, as indicated in their policy. The Director of Environmental Services agreed with the findings. 5) During an interview on 03/18/26 at 11:30 AM, when asked to provide evidence of education related to scabies, the ICP stated it was ongoing. When asked specifically if education was provided in November 2025 with that outbreak, the ICP stated it was. The ICP was asked to locate and provide documented staff education.The ICP provided evidence of education for scabies outbreak to 21 staff on 12/08/25, 33 staff on 01/21/26, and 37 staff on 01/13/26. The ICP was unable to locate any training from October of November of 2025.