STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105516	A. BUILDING _____ B. WING _____	**07/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor a resident's right to communicate with family during COVID-19 pandemic, for 1 of 3 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An annual comprehensive assessment dated [DATE] documented the resident was cognitively intact, and required extensive assistance of one person for activities of daily living. Resident #1 was care planned for communication problem related to hearing deficit. An intervention to place hearing aid in every morning was dated 07/21/20. A review of Resident #1's physician orders [REDACTED]. Follow directions on hearing aids. Open battery door to conserve batteries. Store in Medication cart. An additional order dated 02/21/20 documented to Place Phonack hearing aids in both ear. Dock behind ears every AM (morning). Follow directions on hearing aids for placement. Store in Medication Cart. Record review revealed Resident #1 was moved into the COVID unit on 07/15/20. Observation of Resident #1 on 07/20/20 at 1:00 PM revealed the resident sitting up in a wheelchair in two hospital gowns. Resident #1 seemed to not understand what the surveyor was questioning. No hearing devices were noted in the resident's ears. A cell phone was noted on the resident's bed side table. It was noted the phone was not plugged in. Resident #1 was observed again on 07/21/20 at 1:00 PM sitting up in a wheelchair in a hospital gown. During an attempted interview, the resident stated she could not hear the surveyor because she did not have her hearing aids. The resident further stated she had not heard from her family, as she did not have her phone charger. An interview was conducted with Resident #1's nurse on 07/21/20 at 1:30 PM. The nurse stated someone had brought her the resident's hearing aids this morning. The nurse stated she did not know where they came from. The nurse retrieved the hearing aids from her medication cart. The nurse stated she would inquire about the resident's phone charger and clothing. Resident #1's room was changed on 07/15/20, when she was moved to the COVID unit, and her personal communication devices, including her hearing aides and phone charger, were not moved with her and therefore she was not able to communicate with her family for at least 5 days.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide ordered medications in a timely manner, and failed to provide care and services to meet the needs for 2 of 3 sampled residents (Residents #2 and #3). Specifically, ensuring oxygen was available when needed (Resident #2) and ensuring documentation of a fall, an assessment post fall, and notification to the family and physician after the fall (Resident #3). The findings included: 1) An interview was conducted with Staff A and B (two Department of Health nurses) on 07/20/20 at 2:00 PM. Staff A and B stated it was their first time in the facility. They further stated they did not receive orientation or report from the off-going night shift, 7:00 PM -7 AM. The nurses further stated at the beginning of their shift at 7:00 AM, they had a resident, Resident #2, with low oxygenation, and all the oxygen tanks, located in the clean donning room at the entrance to the unit, were empty. The nurses were able to obtain an oxygen concentrator from a Certified Nursing Assistant (CNA), to provide oxygen to Resident #2. An oxygen concentrator is used for residents prescribed oxygen, and not for emergency cases, and it can't be transported with the resident. The nurses stated they were grateful for the CNA, as they had searched everywhere, and was not familiar with that type of oxygen. One nurse identified herself as an operating room/recovery room nurse. The other nurse stated she was a medical/surgical nurse. The nurses further stated they were still passing morning medications at 2:00 PM, as they were unfamiliar with the residents, procedure, and unfamiliar to taking care of 12 patients at a time. A review of Resident #2's record did not reveal any documentation of the resident's respiratory distress, low oxygenation, or any notification of a physician. A review of the resident's vital signs revealed: 7/19/20 at 10:30 PM oxygen saturation 89% on room air, 7/20/20 at 5:01 AM 90% on room air, and 7/21/20 at 5:59 AM 93% on oxygen. It was not documented when the oxygen was applied, and how much. An observation of the unit's crash cart with the unit manager on 07/20/20, at 2:15 PM, revealed the crash cart was unsecured, and there was no oxygen located on the cart. The daily Emergency Crash Cart log was last completed on 7/10/20. 2) An interview was conducted with Staff C and D (two sister facility CNAs) on 7/20/20 at 2:30 PM. Staff C and D revealed they did not get any orientation or report when they started their shift. The CNAs stated Resident #3 had two falls that morning, and it was reported to the nurse. Staff C and Staff D stated they witnessed Resident #3 on the floor beside her bed. They said they assisted the resident back to bed. The resident did not appear to have any injuries, but did not know if the nurse assessed the resident. Record review revealed Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #3 was care planned for Resident is at risk for falls due to Confusion, Gait/balance problems, Incontinence, Vision problems, Dementia, [MEDICAL CONDITION] disorder. Prefers to stay on mat on side of bed. S/P falls on 3/3/2019, 4/12/2019, 4/28/19, 6/13/2019, 7/17/2019, 8/6/2019, 8/13/2019, 11/27/2019, 12/09/19, 12/13/2019, 12/23/19,1/10/2020, 2/26/2020, 5/10/2020, 5/26/2020, 5/27/20, 7/4/2020, 7/16/2020. A review of Resident #3's record did not reveal any documentation of a fall, an assessment post fall, or notification to the family and physician.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on observation, interview, and facility staffing review, the facility failed to ensure to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety for 2 of 3 sampled residents (Resident #2 and #3). The findings included: An interview was conducted with Staff A and B (two Department of Health nurses) on 07/20/20 at 2:00 PM. Staff A and B stated it was their first time in the facility. They further stated they did not receive orientation or report from the off-going night shift, 7:00 PM -7 AM. The nurses further stated at the beginning of their shift 7:00 AM-7:00 PM, they had a resident, Resident #2, with low oxygenation, and all the oxygen tanks located in the clean donning room at the entrance to the unit, were empty. The nurses were able to obtain an oxygen concentrator from a Certified Nurse Assistant (CNA). The nurses further stated they were still passing morning medications at 2:00 PM, as they were unfamiliar with the residents, procedure, and unfamiliar to taking care of 12 patients at a time. An interview was conducted with Staff C and D (two sister facility CNAs) on 7/20/20 at 2:30 PM. Staff C

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

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.

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and D revealed they did not get any orientation or report since they started at the facility on 07/17/20 on day shift, 7AM-7PM. Staff C and D stated there was one nurse on Saturday 07/18/20. They further stated there was one CNA last night (07/19/20) for 25 residents. They stated the CNA was an RN (registered nurse), but worked as a CNA from DOH (department of health). The CNAs further stated Resident #3 had two falls that morning, and it was reported to the nurse. Staff C and Staff D stated they witnessed Resident #3 on the floor beside her bed. They said they assisted the resident back to bed. The resident did not appear to have any injuries, but did not know if the nurse assessed the resident. A review of Resident #3's record did not reveal any documentation of a fall, an assessment post fall, or notification to the family and physician. An observation of the unit's crash cart, located in an alcove in the middle of the hallway, with the unit manager (UM) on 07/20/20 at 2:45 PM revealed the crash cart was unsecured, and there was no oxygen located on the cart. The daily Emergency Crash Cart log was last completed on 7/10/20. The UM stated the crash cart should be checked daily, and it was the nurse's responsibility to do so. An interview was conducted with staffing coordinator on 07/20/20 at 4:00 PM. The staffing coordinator stated an agency CNA from DOH came in Sunday night 07/19/20. The coordinator further stated the CNA was sent home because the CNA was not on the schedule and no one put the CNA on the schedule. The coordinator stated she should have put the CNA on the schedule, but forgot. The coordinator confirmed they use DOH to supplement staffing needs, and sometimes have RNs work as CNAs. The coordinator confirmed an RN from DOH worked on the COVID unit as a CNA on 07/19/20. The coordinator stated some DOH/agency staff have showed up and left, they stated they are used to only working with 6-8 patients. The facility's daily staffing sheet did not reflect call offs and no shows. The coordinator called two employees by phone, in front of surveyor, to inquire/confirm who they worked with. The coordinator confirmed there was no sign in sheet. An interview was conducted with the NHA (nursing home administrator) and DON (director of nursing) on 07/20/20 at 4:30 PM. They verified no sign in sheet for staffing agency/DOH staff. They stated they can get invoices from the agencies. The staffing agency invoices were supplied on 07/21/20 at 2:00 PM. The invoices did not reflect the daily staffing sheets.
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 observation, interview, and facility log review, it was determined the facility failed to screen staff prior to the start of their shift, and failed to provide proper PPE (personal protective equipment to staff working with residents on transmission-based precautions, intended to prevent the spread of COVID-19 on 4 of 5 wings (A, B, C, D), which had the potential to affect 90 of 90 residents who were quarantined. The findings included: Per CDC guidance: Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms. All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown (Responding to COVID-19 in Nursing Homes: Resident Cohorting updated 04/31/20). Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19. Although screening for symptoms will not identify asymptomatic or pre-symptomatic individuals with [DIAGNOSES REDACTED]-CoV-2 infection, symptom screening remains an important strategy to identify those who could have COVID-19 so appropriate precautions can be implemented (Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic: Summary of Changes to the Guidance, Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic, Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19 updated 07/15/20). Take steps to ensure that everyone adheres to source control measures and hand hygiene practices while in a healthcare facility o Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand sanitizer (ABHS) with 60-95% alcohol, tissues, and no-touch receptacles for disposal, at healthcare facility entrances. Limit and monitor points of entry to the facility. Consider establishing screening stations outside the facility to screen individuals before they enter. Screen everyone (patients, HCP, visitors) entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with [DIAGNOSES REDACTED]-CoV-2 infection and ensure they are [MEDICATION NAME] source control. o Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature ?100.0F or subjective fever. o Ask them if they have been advised to self-quarantine because of exposure to someone with [DIAGNOSES REDACTED]-CoV-2 infection. An interview was conducted with the Nursing Home Administrator (NHA) on 07/16/20 at 11:00 AM. The NHA confirmed the facility census was 151. The facility had 34 residents who were confirmed to have COVID-19 , and the remainder 117 residents were quarantined due to possible exposure to 45 staff members who tested positive for COVID-19 (tested [DATE] and results received between 07/11-07/12/20), and/or contact with the positive residents. The COVID-19 unit on West Wing, had a 39 bed capacity, which the NHA stated they were considering expanding into D wing. A subsequent interview was conducted with the NHA on 07/21/20 at 10:30 AM, and he stated the facility had done surveillance testing for COVID-19 on 07/17/20 on all residents. Results received, and the facility now had 61 residents confirmed positive for COVID-19, and the remainder 90 residents remain quarantined. During a tour of the facility on 07/16/20 at 12:00 PM, with the Assistant Director of Nursing, and Unit Manager, it was explained that A wing, B wing , C wing, and D wing (the entire facility except the COVID-19 unit, located on the west wing, with a dedicated entrance) was quarantined due to exposure to the COVID-19 virus. The entrance to these wings was through the A wing side door. It was observed that the entrance to the observation unit/PUI (persons under investigation unit) on the A wing, did not have a screening station (someone assigned to take the temperature of anyone who enters A wing, and answers a questionnaire related to exposure/possible exposure to the COVID-19 virus). The entrance also did not have a PPE (personal protective equipment) station set up to supply PPE (mask and face shield required for A wing entrance) to persons entering. It was noted that the donning/ doffing Mandatory COVID-19 Screening and PPE Station (signage on the door) was located in a room beyond the entrance, down to the end of the hallway. Staff/personnel had to enter the building and walk through the unit to the end of the hallway to be screened and access PPE, with possible exposure and/or contamination. A tour with ADON and UM of the A wing on 07/16/20 at 12:45 PM revealed a certified nursing assistant (CNA), Staff A, in a resident's room providing care, without a gown on. The ADON and UM acknowledged the CNA should have had on a gown while providing care to the resident. A sign on the resident's door revealed the resident was on contact and droplet precautions, and a PPE station was noted outside the resident's room door. A tour with the ADON and UM of the B wing, another observation unit) on 07/16/20 at 12:55 PM revealed a CNA, Staff B, in a resident's room providing care. Staff B did not have on a gown or a face shield/eye protection. The ADON and UM acknowledged Staff B should have had on a gown and face shield while providing care to the resident. Upon Staff B exiting the resident's room, surveyor questioned about the lack of PPE (gown or face shield). Staff B stated he was from a sister facility, and that's how they did it there. A sign on the resident's door revealed the resident was on contact and droplet precautions, and a PPE station was noted outside the resident's room door. A tour with ADON and UM of the C wing, another observation unit, on 07/16/20 at 1:10 PM revealed two CNAs providing care in resident's room without a gown on. The ADON and UM acknowledged the CNAs should have had on a gown while providing care to the resident. One CNA, Staff C, upon exiting stated she just went in for a minute. A sign on the resident's door revealed the resident was on contact and droplet precautions, and a PPE station was noted outside the resident's room door. A post tour interview with the DON, ADON, and UM on 07/16/20 at 1:30 PM confirmed staff/personnel were to be screened prior to entering the facility at entrance. They also stated all personnel were to wear an N95 mask and a face shield/eye protection prior to entering the observation units, and that gowns and gloves were to be worn when providing resident care. An observation of Staff D, a CNA, on 07/16/20 at 2:50 PM, entering the facility A wing with a surgical mask on. Staff D was not screened. Surveyor questioned Staff D about PPE. Staff D stated she was from a sister facility, and had to get an N95 mask. Staff D did not have on a face shield/eye protection. Observation of the COVID 19 unit, on West Wing, on 7/21/20 at 11:00 AM, revealed a lack of division from the clean area at the entrance near the donning area. The plastic divider at the front entrance was hanging down. An interview with Staff E, a CNA, stated the plastic keeps falling down when EMS comes through. The donning area, previously a semi-private resident room, was the same room as the doffing area. The room was an open area, that contained clean PPE to the left side of the wall. A handwashing sink was available. A trash can was noted on the wall, next to the clean PPE supply. Used PPE (gown, gloves, and booties) was brought into the clean area to be discarded.