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 _____	**07/29/2020**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to notify residents and responsible parties of COVID-19 testing and COVID-19 test results. The facility also failed to notify responsible parties of room changes. This failure affected 3 of 6 residents reviewed for notifications. (Resident #6, Resident #7 and Resident #8). The findings included: 1. During a telephone interview on 07/28/20 at 12:20 PM the responsible party, for Resident #6, stated that her mother had been at the facility for several years and the family would visit every day. The family member stated that after the facility started the 'no visitation policy' in mid-March, because of COVID-19, the family would visit Resident #6 through the window of Resident #6's room. The family member stated that Resident #6 had been in the same room since admission in 2018. The family member stated that they would call the facility and tell the staff when they were coming so that staff could open the blinds and the family could visit. The family member stated that on 07/17/20 she called the facility to tell the staff that the family was coming to the facility to celebrate Resident #6's birthday. The family member stated that on 07/17/20 her mother looked sick and informed the staff about her concerns. The family member stated that she called the facility everyday and asked how her mother was doing. On 07/24/20, the family member called the facility and told Staff E, Social Service Director, that the family was coming to visit Resident #6. Staff E told the family member that Resident #6 was not in her room she was in the lockdown unit (COVID Unit). The family member asked Staff E You mean to tell me my mom has COVID-19, and no one called me?. Staff E terminated the call without confirming Resident #6's COVID-19 status. The family member stated that she made several attempts to contact the facility on 07/24/20 and was told staff were in meetings. The family member called the local Police and requested a wellness visit for Resident #6. The family member met with a Police Officer (PO) midafternoon of 07/24/20 and the PO confirmed that Resident #6 was in the COVID Unit. The family member stated that the facility had never told her that her mother, Resident #6, was being tested for COVID-19 and they had never told her that she was positive and the facility never informed her that Resident #6 room had changed. Review of Resident #6's record on 07/28/20 revealed that the resident was originally admitted to the facility on [DATE]. Resident #6 record revealed [DIAGNOSES REDACTED]. Resident #6 most recent comprehensive assessment, the Minimum Data Set (MDS) of 05/13/20 revealed a Brief Interview for Mental Status (BIMS) of 4 of 15, which indicates severely impaired cognition. Review of Resident #6's Physician order [REDACTED].#6 to be tested for COVID-19. Further review of the record revealed no documentation of COVID-19 testing results. Review of the record revealed that Resident #6 was transferred to the COVID Unit on 07/21/20. Further review revealed no documentation that the responsible party/family member, was notified of the COVID-19 testing, the COVID-19 [DIAGNOSES REDACTED]. During an interview on 07/28/20 at 1:40 PM, Staff D, the Assistant Director of Nursing and the Infection Preventionist, was asked for the laboratory results for Resident #6's COVID-19 test. Staff D was unable to produce the laboratory results. Staff D was asked to find the physician order [REDACTED]. Staff D stated that nursing should have notified the family of the results and that Social Services notifies the families about room changes. Staff D stated that she is not sure why the record is missing documentation, stating that several staff are out related to COVID-19. During an interview on 07/28/20 at approximately 2:00 PM, Staff E, Director of Social Services stated that she does the room change notifications. When asked about Resident #6's 07/21/20 notification Staff E stated that she did not do Resident #6's notification. 2. Record review on 07/28/20 for Resident #7 revealed an original admission of 10/02/19. Resident #7's [DIAGNOSES REDACTED]. Resident #7 most recent comprehensive assessment, the Minimum Data Set (MDS) of 07/05/20 revealed a Brief Interview for Mental Status (BIMS) of 7 of 15, which indicates severely impaired cognition. Resident #7's room was changed on 07/14/20, 07/15/20, 07/20/20 and 07/27/20. Further review of Resident #7's record revealed that the responsible party, her son, was not informed of the room changes on 07/15/20, 07/20/20 or 07/27/20. 3. Record review on 07/28/20 for Resident #8 revealed an original admission of 01/01/19. Resident #8's [DIAGNOSES REDACTED]. Resident #8 is in the facility's COVID Unit. Resident #8's most recent comprehensive assessment, the Minimum Data Set (MDS) of 05/22/20 revealed a Brief Interview for Mental Status (BIMS) of 7 of 15, which indicates severely impaired cognition. Resident #8 had a physician's orders [REDACTED]. Resident #8's room was changed 07/06/20, 07/16/20, 07/30/20. Further review of the record revealed no documentation of notification to the family of COVID-19 testing, diagnosis, or room change to the COVID Unit.
F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to have evidence of informing residence and representatives of COVID-19 testing, test results, completed as per physician order, or that residents were exposed to COVID-19 positive residents, for 5 of 6 sampled residents (Residents # 6, 8, 9, 10 and 12). The findings included: 1. During a telephone interview on 07/28/20 at 12:20 PM the representative, for Resident #6 stated that her mother had been at the facility for several years and the family would visit every day. The family member stated that after the facility started the no visitation policy in mid-March, because of COVID-19, the family would visit Resident #6 through the window of Resident #6's room. On 07/24/20 the family member called the facility and told Staff E, Social Service Director, that the family was coming to visit Resident #6. Staff E told the family member that Resident #6 was not in her room she was in the lockdown unit (COVID Unit). The family member asked Staff E You mean to tell me my mom has COVID-19, and no one called me?. Staff E terminated the call without confirming Resident #6's COVID-19 status. The family member stated that she made several attempts to contact the facility on 07/24/20 and was told staff were in meetings. The family member call the West Palm Beach Police and requested a wellness visit for Resident #6. The family member met with a Police Officer (PO) midafternoon of 07/24/20 and the PO confirmed that Resident #6 was in the COVID Unit. The family member stated that the facility had never told her that her mother, Resident #6, was being tested for COVID-19 and they had never told her that she was positive, and the facility never informed her that Resident #6 room had changed. Review of Resident #6's record on 07/28/20 revealed that the resident was originally admitted to the facility on [DATE]. Resident #6 record revealed [DIAGNOSES REDACTED]. Resident #6 most recent comprehensive assessment, the Minimum Data Set (MDS) of 05/13/20 revealed a Brief Interview for Mental Status (BIMS) of 4 of 15, which indicates severely impaired cognition. Review of Resident #6's Physician order [REDACTED].#6 to be tested for COVID-19. Further review of the record revealed not documentation of COVID-19 testing results. Review of the record revealed that Resident #6 was transferred to the COVID Unit on 07/21/20. Further review revealed no documentation that the responsible party, the family member, was notified of the COVID-19 testing, the COVID-19 [DIAGNOSES REDACTED]. During an interview on 07/28/20 at 1:40 PM Staff D, the Assistant Director of Nursing & the Infection Preventionist, was asked for the laboratory results for Resident #6's COVID-19 test. Staff D was unable to produce the laboratory results. Staff D was asked to find the physician order [REDACTED]. Staff D stated that nursing should have notifies the family of the results and that Social Services notified the families about room changes.

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 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Staff D stated that she is not sure why the record is missing documentation, stating that several staff are out related to COVID-19. During an interview on 07/28/20 at approximately 2:00 PM Staff E, Director of Social Services stated that she does the room change notifications. When asked about Resident #6's 07/21/20 notification Staff E stated that she did not do Resident #6's notification. 2. Record review on 07/28/20 for Resident #8 revealed an original admission of 01/01/19. Resident #8's [DIAGNOSES REDACTED]. Resident #8 is in the facilities COVID Unit. Resident #8's most recent comprehensive assessment, the Minimum Data Set (MDS) of 05/22/20 revealed a Brief Interview for Mental Status (BIMS) of 7 of 15, which indicates severely impaired cognition. Resident #8 had a physician's orders [REDACTED]. Further review of the record revealed no documentation of notification of COVID-19 testing or [DIAGNOSES REDACTED]. During a record review on 07/29/20 for Resident #12, it was revealed that the resident was transferred to the hospital on [DATE]. Resident #12 tested positive for COVID-19 on 07/16/20. Review of facility census for 07/15/20 revealed that Resident #12 was in East Wing room [ROOM NUMBER] and had two roommates (Resident #9 and Resident #10). 4. Record review on 07/29/20 for Resident #9 revealed an original admission of 06/22/17. Resident #9's [DIAGNOSES REDACTED]. Resident #9's most recent comprehensive assessment, the Minimum Data Set (MDS) of 06/07/20 revealed a Brief Interview for Mental Status (BIMS) of 5 of 15, which indicates severely impaired cognition. Resident #9 had a physician order [REDACTED]. Further review of Resident #9's record revealed no documentation that Resident #9's representative was notified of the known exposure to COVID-19. During a telephone interview on 08/04/20 at 11:00 AM Resident #9's representative stated that the facility had not notified her of the residents known exposure to COVID-19. The representative stated that she had not been notified of any testing for Resident #9. 5. Record review on 07/29/20 for Resident #10 revealed an original admission of 11/11/19. Resident #10's [DIAGNOSES REDACTED]. Resident #10 had a physician order [REDACTED]. Further review of Resident #10's record revealed no documentation that Resident #10 or her representative were notified of the known exposure to COVID-19. During an interview on 07/29/20 at 12:40 PM Staff D, the Assistant Director of Nursing, stated that she was unable to verify that Resident #9 or Resident #10 had been tested for COVID-19 after known exposure. Staff D stated that Resident # 9's representatives should have been notified of known COVID-19 exposure and for resident COVID-19 testing.