Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910377	A. BUILDING: _____ B. WING _____	06/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF DELRAY EAST	14555 SIMS ROAD DELRAY BEACH, FL 33484

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced licensure Complaint survey, 2020008898, was conducted on . . . . . through , through . . . . . and . . . . . at Grand Villa of Delray East. The facility had a deficiency identified at the time of the survey.	A 000		
A 030	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close	A 030		

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A 030	Continued From page 1	A 030		

proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and universal precautions; and,
8. The requirements for coordinating the delivery of services to residents by third party providers.
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.

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A 030	Continued From page 2 (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence,	A 030		

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A 030	Continued From page 3 autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making for health care services, the provision of or arrangement of transportation to health care , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency	A 030		

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A 030	Continued From page 4 relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility	A 030		

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A 030	Continued From page 5 must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observations, interviews, record review and policy review, the Assisted Living Facility (ALF) failed to follow CDC (Centers for Control and Prevention) control guidelines to ensure the health, safety and well-being of residents from the potential to contract or transmit the COVID-19 by failing to ensure administrative oversight to assess, implement, evaluate and monitor their preparedness for response to the COVID-19 pandemic. This failure increased the risk to all	A 030		

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A 030	Continued From page 6 residents and directly affected 20 of 24 residents residing in the Memory Care unit of the ALF who [illegible] the COVID-19 [illegible] (Residents #4, 5, 7, 8 and 11 through 27). This is evident of the facility failure to implement timely procedures to eliminate the spread of the [illegible] in the Memory Care unit upon notification of the first confirmed case, a staff member on [illegible] and a Resident on [illegible]. The facility also failed to reduce the risk of continued exposure of the COVID-19 to other residents in the Memory Care and the ALF (non-memory care unit). The findings included: The CDC documents individuals who are 65 years and older, those with [illegible] underlying medical conditions, and those living in residential communities are at high risk for developing serious complications from COVID-19 illness. Individuals who are [illegible] could develop serious [illegible] with difficulty breathing, and might require intensive care for the treatment of multi-organ failure, [illegible], failure, and [illegible]. COVID-19 [illegible] can lead to [illegible]. COVID-19 is a new [illegible], caused by a new Coronavirus that has not previously been seen in humans. Currently, there is no [illegible] and no approved treatment for COVID-19 [illegible], which is a highly transmissible [illegible]. See generally, Publications of the Centers for [illegible] Control. On [illegible], The Office of the Governor of Florida issued Executive Order Number 20-51 directing the Florida Department of Health to issue a Public Health Emergency. The Executive Order documented, "Coronavirus [illegible] 2019 (COVID-19) is a severe acute [illegible], [illegible], illness that can spread among humans through	A 030		

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A 030	Continued From page 7	A 030		

, transmission and presents with symptoms similar to those of ." Section 2 directed the State Health Officer to take any action necessary to protect the public health. Section 3 directed the State Health Officer to follow the guidelines established by the CDC (Centers for Control and Prevention) in establishing protocols to control the spread of COVID-19. Section 4 designated the Florida Department of Health as the lead state agency to coordinate emergency response activities among the various state agencies and local governments.

On , The Office of the Governor of Florida issued Executive Order Number 20-52 declaring a state of emergency for the entire State of Florida as a result of COVID-19.

The President of the United States declared a Nationwide emergency for COVID-19 on and approved a major disaster declaration for Florida on .

On , the Agency for Health Care Administration (AHCA), the state survey agency, issued an Alert entitled, "Residential and Long Term Care Facilities to Implement Universal Use of Masks". The directive stated, Effective immediately staff of residential and long term care facilities are to implement universal use of masks while in the facility. All staff, essential healthcare visitors and anyone entering the facility are to don a mask upon the start of their shift or visit and only change it once it becomes moist. It is important to keep away from the mask and only touch the straps of the mask. Gloves are to be worn when providing care to the resident. Continue to perform hygiene prior to donning gloves, after removing

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A 030	Continued From page 8 gloves, and anytime there is contact with the resident environment. Staff in a room with a patient with . . , . . . , symptoms of unknown cause or a patient with known or suspected COVID-19 should adhere to Standard, Contact, and Droplet Precautions with , protection. This includes wearing gown, gloves, N95 mask (as fitted and available - if not available, at least a . . . . mask), and , . protection such as . . . shields or goggles. In addition to securing more gowns, gloves, and masks, facilities will need to immediately order the appropriate , protection (I.e. . . . shields) since many do not have this on . In the event you are unable to acquire the necessary PPE, please notify your local emergency management agency. Facilities will need to educate their staff on the proper donning (putting on), doffing (taking off), and disposal of any PPE. Information about the recommended duration of Transmission-Based Precautions is available in the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19. The CDC documents the COVID-19 is thought to spread mainly through close contact from person-to-person, and that the best way to prevent the illness is to avoid being exposed to the . Ways to slow the spread of the include maintaining good social distancing, . . . hygiene, use of . . cloths, and routine cleaning and . . . . . of frequently touched surfaces. As of . . . . . (and re-enforced on . . . . .), CDC guidance related to Prevention and Control (IPC) Guidance for Memory Care Units documents, "Routines are very important for residents with . Try to keep their environment and routines as consistent as	A 030		

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A 030	Continued From page 9 possible while still reminding and assisting with frequent hygiene, social distancing, and use of cloth coverings (if tolerated). ... Frequently clean often-touched surfaces in the memory care unit, especially in hallways and common areas where residents and staff spend a lot of time." Review of the "Considerations when preparing for COVID-19 in Assisted Living Facilities" guidelines published by the CDC on , revealed facility staff must encourage the residents to remain inside their bedrooms as much as possible and must have residents wear a covering whenever they were not inside their bedrooms, regardless of whether a resident had any symptoms. Review of the "To prevent spread of COVID-19 in their facilities", guidelines published by the CDC on , ALFs should take the following actions: Identify a point of contact at the local health department to facilitate prompt notificatins as follows: Immediately notify the health department about any of the following: If COVID-19 is suspected or confirmed among residents or facility persnnel; If a resident develops severe , , resulting in hospitalization; If 3 or more residents or facility personnel develop new-onset , , symptoms with 72 hours of each other. Prompt notification of the health department about residents and personnel with suspected or confirmed COVID-19 is critical. The health department can help ensure all recommended prevention and control measures are in place. Often, when a new-onset is identified , there are others in the facility who are also but who do not yet have symptoms. Rapid action to identify, , and test others who might be is critical to prevent the	A 030		

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A 030	Continued From page 10 spread. 1) During the Entrance Conference on [redacted] at 9:25 AM, the Administrator and Director of Nursing (DON) were asked to provide a list of all staff members who had a COVID-19 test with positive results, and a current resident census, indicating who had tested positive for the COVID-19 [redacted]. The Administrator provided the staff list, and the census, and explained all the positive resident cases were confined to the Memory Care unit. The Administrator provided the Memory Care unit census that revealed Residents #11 through 27 (16 total), had all been tested and were positive for the COVID-19 [redacted]. The Administrator stated these 16 residents were transferred out to the hospital. The census revealed there were eight remaining current residents in the Memory Care unit. When asked about caring for any resident who tested positive for the COVID-19 [redacted], the Administrator stated they were not going to care for any positive residents as they could decompensate quickly. The Administrator stated they promptly transfer any resident who tests positive for the COVID-19 out to the hospital. Review of the list of staff members provided by the Administrator revealed the following: A. Staff L, a Resident Care Assistant and Medication Technician who worked in the memory care unit at night, tested positive on [redacted] by an outside laboratory. In a telephone interview conducted on [redacted] at 2:54 PM, Staff L confirmed this information. In a telephone interview conducted on [redacted] beginning at 9:27 AM, the facility's Regional Director of Operations and the Administrator stated Staff L called the then Director of Nursing to report she	A 030		

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A 030	Continued From page 11 was "totally not feeling well" on . They also stated the results of her initial test was provided to them by the Department of Health on . B. Staff M, a Laundry Worker who worked throughout the facility (including Memory Care Unit), tested positive on . Her last day of work was . She was . She returned to work on per telephone interview with the Administrator on at 9:27 AM. C. Staff F, the Activities Program Director who worked throughout the facility, tested positive on . Per telephone interview with the Administrator on at 9:27 AM, she has not returned to work. In a telephone interview conducted on at 10:40 AM, Staff F confirmed this information. She was . D. Staff N, a Resident Care Assistant who worked in the memory care unit, tested positive on . Per telephone interview with the Administrator on at 9:27 AM, she has not returned to work. E. Staff O, a Resident Care Assistant who worked in the memory care unit, tested positive on . In a telephone interview conducted on at 3:02 PM, Staff O confirmed this information. Per telephone interview with the Administrator on at 9:27 AM, she has not returned to work. F. Staff P, a Resident Care Assistant who worked in the memory care unit, tested positive on . In a telephone interview conducted on at 10:30 AM, Staff P confirmed this	A 030		

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A 030	Continued From page 12	A 030		

information. Per telephone interview with the Administrator on at 9:27 AM, she has not returned to work.

G. Staff Q, a Resident Care Assistant who worked in the memory care unit, tested positive on . In a telephone interview conducted on at 3:39 PM, Staff Q confirmed this information. Per telephone interview with the Administrator on at 9:27 AM, she has not returned to work.

Review of the resident list provided by the Administrator revealed 16 residents (Resident #11-#26) tested positive for the .

Record review revealed Residents #11 through #26 were all tested for the COVID-19 with positive results reported between and as follows:

A. Resident #14 was sent to the hospital after a on and subsequently tested positive on .

B. Resident #25 was sent to the hospital after a on and subsequently tested positive at the hospital on .

C. Resident #23 was sent to the hospital after a on and subsequently tested positive at the hospital on . He was subsequently placed on hospice services and , on .

D. Resident #24 tested positive by the ALF on with complaints of , a change in mobility, and a non-productive . This resident was sent to the hospital.

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A 030	Continued From page 13 E. Resident #11 tested positive on [redacted] by the ALF and was sent out to the hospital. The record lacked any documented COVID-19 symptoms. F. Resident #12 tested positive on [redacted] by the ALF and was sent out to the hospital. The record lacked any documented COVID-19 symptoms. G. Resident #13 tested positive on [redacted] by the ALF and was sent out to the hospital. The record lacked any documented COVID-19 symptoms. H. Resident #18 tested positive on [redacted] by the ALF and was sent out to the hospital. The record lacked any documented COVID-19 symptoms. I. Resident #19 was sent to the hospital after a [redacted] on [redacted] and subsequently tested positive at the hospital. She [redacted] in the hospital on [redacted]. J. Resident #21 tested positive on [redacted] by the ALF and was sent out to the hospital. The record lacked any documented COVID-19 symptoms. She subsequently returned to the facility after receiving treatment at the hospital. K. Resident #15 tested positive on [redacted] by the ALF with complaints of [redacted] (drowsiness). The resident was sent out to the hospital. She was subsequently placed on hospice services and [redacted] on [redacted]. L. Resident #20 tested positive on [redacted] and was sent out to the hospital. The record lacked any documented COVID-19 symptoms.	A 030		

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A 030	Continued From page 14 M. Resident #26 tested positive on by the ALF and was sent out to the hospital. The record lacked any documented COVID-19 symptoms. O. Resident #17 tested positive on by the ALF with complaints of and an saturation level of 90% (normal is usually in the upper 90s). The resident was sent out to the hospital. P. Resident #22 was identified on the requested census as having tested positive and sent out to the hospital. She was placed on hospice services and , (date unknown as requested document was not provided). Q. Resident #5 was transferred to the hospital and subsequently transferred to a hospice house on . She , on . R. Resident #16 was identified on the requested census as having tested positive on . She was sent to the hospital, and , on . Based on information received by the ALF on at 3:24 PM: S. Resident #8 was identified on the requested census as not having tested positive for COVID-19. She was identified as having tested positive on or around . T. Resident #7 was identified on the requested census as not having tested positive for COVID-19. She was identified as having tested positive on or around .	A 030		

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A 030	Continued From page 15 Review of the information provided from the facility regarding the staff and residents that tested positive revealed the following. On [redacted], the facility became aware of the first positive case of COVID-19, Staff L, a Resident Care Assistant and Medication Technician who worked in the memory care unit. On [redacted], the facility became aware of the second positive case, Staff B, a Laundry Worker who worked throughout the facility, and whose last day of work was [redacted]. On [redacted], the facility became aware of the third positive case, Staff F, the Activities Program Director who worked throughout the facility. On [redacted], the facility received the fourth positive test result for Staff N, a Resident Care Assistant who worked in the memory care unit. On [redacted], the facility received the fifth positive test result for Staff O, a Resident Care Assistant who also worked in the memory care unit. Based on interviews herein, the facility did not comply with the CDC guideline relating to residents wearing masks when not in their rooms until [redacted] when they received their first positive case of COVID-19, Resident #14, who was transferred to the hospital on [redacted] due to a [redacted]. The resident was tested by the hospital. The facility failed to reduce the chances of the spread of COVID-19 in its memory care community. In correspondence with the Department of Health on [redacted], it was revealed that the facility did not notify the Department of Health of its first positive case of COVID-19 until [redacted]. The second notification of a positive case was received on [redacted]. CDC guidelines state staff should know how to contact the health	A 030		

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A 030	Continued From page 16 department if COVID-19 is suspected or confirmed among residents or facility personnel. Review of an email report dated conducted by the Department of Health, highly encouraged the facility to monitor the movement/behaviors of memory care residents. This report also documented that the facility should modify their assignments considering those with the inability to sit still in a more monitored and confined area with limited opportunities to . In a telephone interview conducted on at 3:19 PM, a representative of the Department of Health stated this information was verbally relayed to facility staff during the inspection. 2) A tour of the memory care unit was conducted on beginning at 10:10 AM by two surveyors. A large pile of "clean" uncovered linens in a metal rolling basket was observed at the end of a short hall, visible from the nurse's station (photographic evidence obtained). Directly next to the basket of "clean" unprotected linens, was a large open bag of personal clothes and a resident wheelchair with used linen in the seat of the chair (photographic evidence obtained). Next to these items was the "Trash Room" which contained a trash chute, and bags of trash were noted on the floor. In an interview conducted at the time of observation, Staff A, a Resident Care Supervisor, and Staff B, a Resident Care Assistant, revealed the wheelchair and dirty linens belonged to Resident #22, a COVID-19 positive resident who was transferred out to the hospital. Staff B picked up the bag of soiled linen to show to the surveyor, put them down on the floor, and then wheeled the "clean" linens down the long hallway to the clean linen storage closet near the end of the hall, and placed the	A 030		

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A 030	Continued From page 17	A 030		

items in the closet. Staff B was wearing a gown as personal protective equipment, as the current eight residents in the unit were considered PUIs (persons under investigation) for the . The pile of "clean" uncovered linens was over twice as high as the actual basket (photographic evidence obtained), and Staff B was using her body to support the stack of linens.

On at 10:19 AM, Resident #1 was observed sitting in a chair in the common area of the memory care unit with her mask worn below her , not covering her and/or . Resident #2 was in the common area, social distancing from Resident #1, but had no mask. At that time, Staff A walked by Resident #1 without instructing her to properly don her mask, and placed a mask on Resident #2. Staff A walked by Resident #1 without any interventions and returned to the nurse's station, which was located at the edge of the common area.

On at 10:30 AM, Resident #1 was observed with her mask now over her , but under her . Staff A remained at the nurse's station but did not intervene. Staff B walked through the common area and did not intervene.

On at 10:35 AM, Resident #1 was observed pulling her mask up over her and , and then down below her .

On at 10:35 AM, Resident #3 was in her room located near the nurse's station, getting ready to leave. Staff J, the Memory Care Housekeeper was cleaning her room, with the cart partially blocking the entrance to the room. Resident #3, ambulating independently with her walker, passed by the housekeeper, and was acknowledged by the housekeeper who did not

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A 030	Continued From page 18 attempt to stop the resident from leaving her room without her mask. The resident ambulated into the common area in front of the nurse's station, and was then provided a mask by Staff J and Staff B. On [redacted] at 10:49 AM, Residents #1, #2, and #3 were observed sitting in the common area in the memory care unit, social distancing, but all three masks were noted below their chins. Staff A, a Resident Care Supervisor, was sitting at the desk, working on the computer during these observations, and did not encourage or re-direct on proper donning of the masks for any of the residents. Staff B walked through the common area directly in front of Resident #1, pushing Resident #4, who was in her wheelchair, into the Activity room. Staff B, a Resident Care Assistant, again walked [redacted] through the common area, past all three residents, and did not encourage or re-direct on proper donning of the masks, which all remained improperly donned. During an interview conducted on [redacted] at 10:53 AM, Staff A, a Resident Care Supervisor, stated residents started using personal protective equipment after the first positive case on [redacted] He also stated staff should always intervene if they see the residents not wearing their masks, or if they are not wearing them properly. During an interview on [redacted] at 10:55 AM, Staff B, a Resident Care Assistant, explained that today was her first day [redacted] and she was unaware of the need for the residents to wear masks. She stated she last worked on [redacted], and at that time the residents were not wearing masks. She further stated that only the staff wore them when she last worked.	A 030		

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A 030	Continued From page 19 In an interview conducted at 4:45 PM, Staff E, the Activity Assistant, who only works in the Memory Care unit, explained they just started having the residents wear masks when they had their first positive COVID-19 case last week. Staff E stated prior to that "the residents were not wearing masks because we didn't have anyone with it (COVID-19). We wore masks because we came in and out of the facility." During the continued observation, a random resident independently walked right passed the Activity Assistant and surveyor to exit the dining room. The residents mask was strapped to her , but under her . The Activity Assistant did not intervene. The surveyor asked if she should assist the resident with her mask, and the Activity Assistant ran down the hall to help her with the mask. During an interview on at 5:15 PM, the Administrator confirmed the ALF practice has been and continues to be that any resident who is out of their room for any reason is to wear a mask. When asked if that included the Memory Care unit, the Administrator stated, "Yes, of course, but it's difficult with the memory care residents." In a telephone interview conducted on at 9:58 AM, Staff I stated the residents in the Memory Care unit started wearing masks on . In a telephone interview conducted on at 10:40 AM, Staff F, the Activities Director, stated that to the best of his/her knowledge, as of , the Memory Care unit residents were not required to wear protective masks.	A 030		

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A 030	Continued From page 20 During a telephone interview on . . . . . at 12:39 PM, Staff T, a Resident Care Supervisor (a nurse) stated she worked in both the Memory Care unit and the ALF. The nurse explained that since there have now been positive COVID-19 residents in the Memory Care unit, they (the staff) have been wearing gowns in addition to their masks, and the residents are now wearing masks. Staff T explained that the staff need to remind the residents about the mask and assist the residents to wear them properly. 3) Facility COVID-19 policy and procedure for the "Transitional Program" dated documents, "Transitional Room Accommodations ... All Transitional Rooms will: ... 5. Have signage on the hallway side of room entry door labeling it as a Transitional Room (a room designated by the ALF for any admission, re-admission, or resident who leaves the facility). ... Staffing and Resident Care for Transitional Room Residents: ... 2. All staff who enter Transitional Rooms will be trained by the Care Manager on specific protocols for proper use of personal protective equipment while providing care to Transitional Room residents. a. This training must be documented via PER-07 Transitional Room Training. 3. All staff who enter Transitional Rooms MUST wear an N95/KN95 facemask, _, protection, gown, and gloves while providing care to Transitional Room residents. 4. Due to the lack of worldwide gown supply at this time, all staff are recommended to wear ONLY one reusable gown per resident for the entire shift. Each gown is to be used for only ONE resident. Upon exiting their room the gown is to be hung on the side of the resident's entry door. The same gown MUST only be worn by the same staff member." The initial observational tour continued on	A 030		

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A 030	Continued From page 21 . . . . . at 11:00 AM, of the rest of the building which was the ALF (non-memory care unit). Most rooms had purple signage that documented, "I am remaining in my room today. Please use sanitizer prior to entering." Other doors had a dark pink/red sign that documented, "Transition Room. Please use . . sanitizer prior to entering." Review of an email report dated . conducted by the Department of Health recommended staff who are assigned to PUIs (Persons Under Investigation, which would include the Transition Room residents) are given full personal protective equipment, including N95 masks with proper storage. The report also documented the Department of Health observed several employees either not wearing a mask or not having the proper mask on. One staff member was using a scarf around her . . and . . . . This information was also shared with the facility's Administrator during the Department of Health visit. During an interview on . . . . . at 11:38 AM, Staff C, a Resident Care Assistant who introduced herself as a Certified Nursing Assistant (CNA), and confirmed she was responsible for the care of residents in the Transition Rooms was asked about the Transition Rooms. The CNA explained the residents in the Transition Rooms had recently been admitted or had to go out of the building for some reason. The CNA explained the Transition Room signage indicated for staff that these residents had to stay in their rooms. The CNA explained that when providing any care for these residents, or when delivering their meals, she would put on full personal protective equipment, including a gown. When asked where the gowns were kept, the	A 030		

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A 030	Continued From page 22 CNA stated in an empty room. The surveyor asked to see the gowns. The CNA took the surveyor into an empty room and pointed to a clear plastic bag on the self in the closet. This bag had one dark blue gown. Upon inquiry, the CNA explained there was one disposable gown in the bag that was for her to use for the care of the two Transition residents in her section (Resident #28 and Resident #27). Observation revealed Transition Room signage for (Resident #28) and 250 (Resident #27). Upon further questioning, the CNA confirmed she used the same gown to provide care and deliver breakfast and lunch to both residents. The CNA explained she received a new gown each day she worked. The CNA was also noted wearing a cloth mask under her N95, stating it was more comfortable and that she always wore the masks in that manner. Review of the facility's COVID-19 training dated through , provided by management, documented Staff C did have training regarding proper use of personal protective equipment. Evidence of the trainings provided to staff lacked any specific training related to Transition Rooms. 4) During the Entrance Conference on at 9:25 AM, the Administrator and DON were also asked for a list of residents who had been re-admitted to the facility since . Residents #9 ( ) and #10 ( ) were two of the six residents who were re-admitted to the ALF. The Administrator confirmed the use of the Transition Rooms for these residents for 14 days. During the initial tour, the rooms for Residents #9 and #10 were observed to lack the designated "Transition Room" signage to notify the staff of the need to	A 030		

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A 030	Continued From page 23 utilize full personal protective equipment. (Photographic evidence obtained). Review of the record revealed Resident #9 was transferred out of the ALF on . . . . . at 2:00 AM for complaints of and . . . The resident returned to the facility, to , on Saturday at about 5:00 PM. An additional observation of . . . . was made on at 4:27 PM. The door lacked the Transition Room signage, and the door was open. Observation of the ALF apartment revealed a small kitchen area to the left, a small dining area to the right, and three doors. Resident #30, the roommate to Resident #9, did not respond to the surveyor's knock on the door or calling out hello, and was sitting at the dining table eating. Staff D, the Housekeeping Supervisor, was in the hallway, and confirmed the identity of Resident #30. Staff D explained each resident occupied their own bedroom but shared the bathroom, kitchen and dining area. During an interview on at 5:15 PM, the Administrator confirmed Resident #9 was re-admitted to the ALF that weekend and should have been re-admitted to a private Transition Room. The Administrator stated he would rectify the concern that same evening. Review of the record revealed Resident #10 was transferred to the hospital on after a , and returned to the ALF on Sunday . . . . at 2:45 PM. An additional observation on at 4:24 PM revealed the resident's door was open, Resident #10 sitting in her room, and there was no "Transition Room" sign on the door. During the continued interview on at 5:15 PM, the Administrator also confirmed	A 030		

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A 030	Continued From page 24 Resident #10 was re-admitted to the ALF that weekend and should have Transition Room signage on the door to alert all staff of the recent admission and the need to the resident, and to utilize full personal protective equipment. Telephone interviews with three Resident Care Supervisors (nursing staff), Staff R, S, and T were conducted on at 12:30 PM, 12:46 PM, and 3:05 PM, respectively. All three nurses were asked who was responsible for ensuring the Transition Room signs are placed on the resident doors as needed. All three nurses were unsure, but stated probably someone in management, the DON, or the nurses themselves. Review of requested COVID-19 training lacked any evidence of training related to use of Transition Rooms (see item six below). 5) During an interview on at 4:35 PM, Staff D, the Housekeeping Supervisor, explained the cleaning of resident rooms in the ALF depends on what type of service is being provided to that resident. She explained that some residents in the ALF receive housekeeping services four times a week, while others receive those services just once weekly. When asked about the Memory Care unit, Staff D explained it is treated more like a nursing home because of the increased needs and , , so those rooms are cleaned daily and as needed. When asked about increased cleaning of high touched surfaces, the Housekeeping Supervisor stated the common areas including doorknobs, the Wellness Center, and elevators are only cleaned each morning by the housekeeping staff, before starting on resident rooms. On at 11:00 AM, Staff J, a Memory Care unit Housekeeper, was observed folding linens in	A 030		

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A 030	Continued From page 25 the laundry room, located just outside the memory care unit, she was not wearing a protective gown or apron. On . . . . . at 2:53 PM, Staff K, an ALF Housekeeper, was asked and stated the resident rooms are cleaned every one to three days and as needed. Review of an email report dated conducted by the Department of Health documented the following: A. When asked how often high touch surface areas are . . . . . , the facility did not mention a consistent timeframe. The Department of Health recommended the facility frequently decontaminate high touch surface areas and provide a time log upon completion throughout the day. B. During the assessment of the laundry area, the Housekeeper placed a basket that was stored on the floor onto clean clothes to maximize space. In a telephone interview conducted on at 3:19 PM, a representative of the Department of Health stated this information was verbally relayed to facility staff during the . . . . . inspection. In a confidential telephone interview conducted . . . . . at 9:31 AM, Staff G provided the following information. S/he worked mostly in the Memory Care unit. As of . . . . . , the residents were not kept in their rooms. Resident #11 returned from the hospital and was to be , but was frequently observed out of her room during the evening hours. There were no masks for the residents. Staff members'	A 030		

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A 030	Continued From page 26	A 030		

requests for masks for themselves were denied, some had to wear bandanas for masks. The Memory Care unit had one housekeeper assigned to clean all 29 resident rooms, and would use the same mop and rag to clean all the rooms. No one came during the night shift to train staff members related to COVID-19, nor were they asked to come in during the day for training. There would be no one at the front door to screen them or take their temperatures upon arrival for their shift; sometimes a nurse would request they come for a temperature in the middle of their shift.

6) Review of the ALF's written policy titled COVID-19 Emergency Response Policy and Procedures dated documented, "With guidance from the Florida Department of Health, Agency for Health Care Administration, Centers for Control, and the State Surgeon General, the Community has prepared the following policy in response to the concerns regrading COVIO-19. The following mitigations have been implemented based on agency recommended guidance to reduce the risk of exposure to the residents, employees and visitors of the Community." Section R. titled Employee Requirements and Training, Item 2 documented, "All staff have been re-educated on community control and universal precaution procedures with high emphasis placed on proper handwashing, sanitizer use, coughing into arm (not), sanitizing high touch surfaces frequently and reporting resident and employees with symptoms."

Review of the following facility training material related to COVID-19 revealed that, out of 90 staff members available for training, including present and prior staff members, staff members were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910377	A. BUILDING: _____ B. WING _____	06/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF DELRAY EAST	14555 SIMS ROAD DELRAY BEACH, FL 33484

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 27 trained as follows (discussed with the Administrator on at 4:17 PM): 1. through PPE Equipment/How to Don PPE - There was documentation only 29 staff members were trained, and 61 staff members were not trained. 2. . . . . Handwashing - There was documentation only 30 staff members were trained, and 60 staff members were not trained. 3. . . . . , ... and . . . . COVID-19 Monitoring and Follow-Up Testing for Returning Residents - There was documentation showing only 21 staff members were trained, and 69 staff members were not trained. 4. . . . . COVID-19 Precautions and Testing - There was documentation showing only 9 staff members were trained, and 81 staff members were not trained. 5. through Existing Employee Symptom Monitoring and Testing - There was documentation showing only 21 staff members were trained, and 69 staff members were not trained. During a telephone interview with the Administrator and Regional Director of Operations on at 9:55 AM, it was confirmed that the facility did not go into full PPE use (mask, gowns, gloves, etc.) until after the first confirmed positive resident (Resident #14). It was also confirmed that the facility implemented a system to test all staff members in groups of 30 staff members per week starting the week of and ending the week of . However, no residents	A 030		

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A 030	Continued From page 28 were tested during the time the staff member were tested. Further interview and review of provided invoices revealed that the facility had hired a third-party company to deep clean the Memory Care Unit on , , and ; 25 days after the facility received notification of the first confirmed positive COVID-19 case which was a staff member. The facility also confirmed no additional steps had been implemented during the first notification of the positive staff member (Staff L) and additional testing of staff prior to the first confirmed positive resident (Resident #14). The concerns contained in this report were discussed with the Administrator and the ALF's Regional Director of Operations by telephone on at 4:02 PM and on at 9:27 AM. Class II	A 030		