From:FLORIDA AGENCY HEALTH 561 496 5924 12:14 #883 P.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2016
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
	105411	A. BUILDING ______ B. WING ______	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBEY DELRAY SOUTH	1717 HOMEWOOD BLVD DELRAY BEACH, FL 33445

(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) COMPLETION DATE

F 000 INITIAL COMMENTS

An unannounced Recertification survey was conducted on through at Abbey Delray South. The facility is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.

F 241 SS=E 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record reviews, it was determined that the facility staff failed to promote care in an environment in the dining , meal service, and answering of call bells that maintains each residents dignity and respect in full recognition of his or her individuality.

The findings included:

1) During the observation of the lunch meal on , breakfast and lunch meals on and , and breakfast meal on it was noted that dietary transport carts are placed in the hallways of the Cypress, Ashley , and Banyon resident units. Further observations revealed that many resident eat their meals in their own . Upon finishing their meals the CNA's remove the resident and scrape garbage/trash into bussing bins located on the transport carts, the soiled dishes are then

F 000

The statements made on the Plan of Correction do not constitute admission of agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws.

F 241

F 241 — 4/10/16

It is the practice of Abbey Delray South to promote and care for residents in a manner and in an environment that maintains or enhances each residents dignity and respect.

Residents receiving tray service in their and all residents and others in the hallways may have been affected by the deficient practice at the time of the survey.

Resident meal trays will no longer be bussed in the hallway. The used tray will be placed in a covered cart and then bussed in the kitchen area.

New tray carts have been purchased to better serve the resident's needs, preserve the cleanliness in the hallways and facilitate the collection of meal trays removed from resident's

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jamie Ransone TITLE: NHA (X6) DATE: 3-23-16

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 241	Continued From page 1 stacked on the cart which is then covered only by a thin bed sheet. On numerous occasions the covering sheet had slipped off the carts exposing the garbage/trash and stacks of soiled dishes. During the observations it was noted that numerous residents are moving about the main hallways and have to pass either the staff scraping the soiled dishes or pass the opened exposed garbage/and trash bins. Interview conducted with administrator on at 10:10 AM revealed that the busing of soiled resident dishes in the resident's main hallways has been going on for some time and was a resident dignity issues and would be addressed immediately. 2) A confidential interview was conducted with a residents on at 10:30 AM, the surveyor asked the resident if staff treated her with dignity and respect. The resident stated 50% of the staff have a bad attitude when providing care. On at 3:30 PM, the resident stated a (CNA) certified nursing assistant again had an bad attitude when providing care. The resident stated she did not want to report the staff because the staff may become upset with her. 3) Obseravations made on of the breakfast meal in the Banyan dining made to include: At 7:30 a.m. one table with 3 female residents was observed with one of the residents being fed oatmeal by an aide and the other 2 residents with no food in front of them. At 7:35 a.m. 6 tables with residents seated at the tables was observed with each table of residents being offered beverages, oatmeal and the main breakfast entre. At 7:45 a.m. 2 tables situated at the back right of	F 241	Dietary and team members will be educated on the new system. The Dietary Supervisor or Nursing Supervisor will monitor the tray removal process to ensure that the trays are covered and not bussed in the hallways. The Dietary or Nursing Supervisor or designee will conduct an audit of meal tray removal 5 times a week for two months and then a sample of 15 meal times for an additional two months to ensure that the tray cart is covered and that trays are not bussed in the hallways. The results of the audits will be reported to the DON and to the QAPI Committee for three months and then quarterly or as determined by the QAPI committee. 2. It is the practice of Abbey Delray to ensure that the resident is treated with dignity and respect. Abbey Delray South expects residents to be provided all levels of care in a manner that promotes a dignified experience and one where there is no fear of reprisal.	4/10/16

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F 241	Continued From page 2 the dining to the windows was observed to have no meal service as yet. One of the tables seated 5 female residents, referred to as 'Table A' and the other table seated 4 female residents and 1 male resident, referred to as 'Table _'. At 7:54 a.m. a resident was brought in to the dining an aide and an attemp to place the resident at 'Table A' was made however there was no the 2 tables to pass through. The aide proceeded to move one female resident from 'Table B' out of the way and the new resident was placed at 'Table A' and then the female resident that was moved was placed back at 'Table B'. At 7:55 a.m. 3 aides were observed seated at 'Table A', then one more aide joined the table. The 4 aides were observed talking amongst themselves and not interacting with the residents. It was observed the residents of the 2 tables had glasses of thickened water in front of them however they were out of their reach and were not being offered a drink by the aides. At 8:00 a.m. 6 tables of residents were observed eating, however 'Table A' and 'Table B' had not been served as yet. At 8:03 a.m. 'Table A' was observed to be offered juice. There were now 5 aides seated at the same table one in between each resident making 10 people cramped around the same table. At 8:05 a.m. 'Table B' had not been served as yet. 8:09 a.m. at 'Table B' it was observed 3 of the female residents were sleeping. One female resident who was able to reach for items on the table was observed to be drinking out of coffee mug however no swallowing action was observed. The coffee mug was observed to be empty and the resident was going through the motion of drinking. The male resident at 'Table B'	F 241	This comment was shared related to a confidential interview. The person who communicated the complaint was not identified to Abbey Delray South team members, therefore the staff was not given an opportunity to make a specific intervention. All residents have the potential to be by this stated deficiency. Team members will be reeducated about customer service skills and resident rights, which include the resident's right to voice a complaint without fear of reprisal. The DON or designee will conduct six resident and/or family interviews a week for three months to determine if the staff are demonstrating a professional attitude. The results of the audits will be presented to the QAPI Committee monthly for three months and then quarterly or as determined by the QAPI committee. 3. Residents in the dining were provided meals as soon as a delay was recognized. Residents who are served in the dining at risk from the same deficiency.	4/10/16

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F 241	Continued From page 3 was observed to be staring over at 'Table A' which was now being served. It was observed that 4 residents were being fed oatmeal and one resident did not receive anything. At 8:11 a.m. the 1 resident at 'Table A' that had nothing was now being served oatmeal and was being fed by an aide. At 8:15 a.m. a female resident at 'Table B' was observed to wake up. Another female resident at the table was observed to open a coffee creamer and drink the creamer. She drank 3 of the creamers then was observed to open up a of butter and with the end of a tablespoon ate the butter. The male resident at the table was observed to continue to stare at 'Table A' where the residents had received their food. At 8:17 a.m. the residents at 'Table A' were being fed oatmeal by the 5 aides sitting at the table. At 8:19 a.m. a female resident wheeled herself into the dining immediately was offered cereal and juice by a dietary aide. At 8:22 a.m. the male resident of 'Table B' continued to look over at 'Table A' who were being fed oatmeal then he was observed to look down at his table and then back at the table that had food then back at his table. His table had not been offered food as yet. At 8:24 a.m. 'Table B' still had no food offered. It was also observed there was no interaction of the numerous staff members with the residents as the staff were milling around the dining . It was observed that no staff were paying any attention to this table with no food. At 8:25 a.m. an aide came to 'Table B' and sat next to the male resident between him and the sleeping female resident. There was still no food at the table and no effort by the aide to initiate the meal service. At 8:26 a.m. the main breakfast entree was	F 241	The Dining and licensed nursing team members will monitor, respond and report occurences where a resident is left at the dining table without food for too long. Team members will intervene as necessary to improve the timeliness of food service delivery. The Dining will ensure that tables are placed in their proper locations before meal service is started to prevent inadequate space for resident chairs and wheelchairs and to ensure ease of movement to and from a table in the dining table. Table placement will be arranged by the Dining in the Health Center to provide for resident movement. The table placement will be audited five times a week for two months and then five times monthly for two additional months and the findings reported to the QAPI Committee each month and then quarterly or as determined by the QAPI committee.	4/10/16

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F 241	Continued From page 4 observed to be served to 2 residents at 'Table A', then another plate of food was brought over making 3 of the 5 residents seated at the table with food and 2 residents without food. The male resident at 'Table B' was observed to now be staring nonstop at 'Table A' who had been served their breakfast. At 8:30 a.m. the dietary aide was observed to be milling around the dining . There was no interaction observed with 'Table B'. The aide that sat down at 'Table B' at 8:25 a.m. got up and went to assist another resident with her breakfast at another table. At 8:31 a.m. another aide came to 'Table B' and sat down between the male resident and the sleeping female resident. The aide was observed to offer the sleeping resident water and she took it. The female resident that was observed at 8:09 a.m. to be drinking from an empty coffee mug continued to drink out of the empty coffee mug. Nobody was observed to offer her a beverage. At 8:32 a.m. a nurse identifying herself as the floor RN on the Banyan unit went to 'Table B' talked to the aide sitting there, then turned around and left. There was still no food offered at 'Table B'. The male resident continued to look over at 'Table A' where they were well into their breakfast meal and then look down at his table where there was no food. Additionally it was noted that the male resident, despite having a glass of thickened water with a straw with the paper still on it, in front of him, did not attempt to reach for the glass and no aide who came and went from the table offered any resident anything to drink. At 8:35 a.m. the aide continued to sit in the same spot with no interaction between her and the residents. A ambulatory male resident was observed to enter the dining as he sat down at a table was immediately offered	F 241	It is the practice at Abbey Delray South that staff communicates effectively and with residents and guests in the dining make the dining experience pleasant and enjoyable. Team members who were deficient in this practice were advised to correct their behavior as it was made known to management during the survey. Residents who dine in the dining at risk for the same deficiency. a. Team members will be re- educated in proper procedures and behaviors expected in the Dining . A comprehensive customer service program will be conducted and will include focusing on residents in conversations in the dining .	4/10/16

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F 241	Continued From page 5 breakfast by a dietary aide. At 8:36 a.m. the aide seated at 'Table B' got up and left. The male resident at 'Table B' continued to keep looking over at 'Table A' who were being fed breakfast. At 8:40 a.m. the same aide came back to 'Table B' and sat down in the same spot as she sat before. At 8:42 a.m. another aide came to 'Table B' and sat down between 2 female residents. The Assistant Director of Nursing (ADON) was observed to come up to the table and say to the 2 aides that 'these residents need encouragement' and she was then overheard to say as she looked at the resident's table "Oh, no food" then proceeded to walk away. At 8:43 a.m. another aide came to 'Table B' and sat down next to the male resident, making a total of 3 aides now seated at the table, and she proceeded to put a clothing protector on him. She then proceeded to take the paper covering off of the straw in his water glass and offer him a drink of water which he readily took. The other aide sitting between the male resident and the sleeping female resident offered the sleeping resident water and she opened her eyes and took a sip. At 8:45 a.m. the ADON was observed sitting at the 'Table A' assisting a resident with feeding. At 8:47 a.m. a dietary aide came to 'Table B' and for the first time offered the residents juice. A glass of juice was put in front of the female resident who drank the coffee creamers and ate the , of butter at 8:15 a.m. and she said to the dietary aide "Thank you" and immediately started to drink, took a sip, put the glass down, picked it up again and took another sip and continued to do this until the juice was almost all gone. At 8:50 a.m. a dietary aide came to 'Table B' and	F 241	b. Nursing and culinary team members who work in the dining be re- educated about procedures expected in the Dining Residents who have beverages will have the beverage placed within their reach and assisted as appropriate. c. The Culinary Manager will be re-educated to observe excess residents are not placed at one table at any given time. Consideration will be given to the number of residents at a table, residents needing assistance and the impact of team members and equipment that may crowd the area. d. Team members will be re-educated regarding residents with limitations on their ability to effectively manage beverages, food and condiments. When such issues occur because of the residents limitations, interventions will be offered. If a resident is attempting to take a beverage glass that has	4/10/16

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F 241	Continued From page 6 said to the 3 aides sitting there "Are you ready?" At 8:51 a.m. the resident that drank the coffee creamer was brought a bowl of oatmeal and she immediately started eating it without adding milk or sugar. 'Table B' was not offered/brought food for 1 hour and 19 minutes while all other residents in the dining eating or were done eating. At 8:52 a.m. the male resident at 'Table B' was brought oatmeal and the aide put sugar and milk in it and offered it to him. He eagerly ate without encouragement. On at 11:54 a.m. a lunch observation was conducted in the Banyan dining the same vantage point. Observation was made of the same 2 tables, 'Table A' which had 5 female residents seated at it and 'Table B' who also had 5 females seated at it without the male resident present. At 11:55 a.m. beverages were observed placed in front of the 5 female residents at 'Table B'. It was observed that 3 of the 5 female residents could not help themselves and required total assist with eating. Observation was made of 2 female residents sitting at the next table against the wall and one resident was brought soup but not the other. At 11:57 a.m. 2 aides were observed sitting at 'Table ' next to the 2 female residents who required assistance and they were not offering them juice or another beverage. They were observed to be just sitting there not interacting with the residents. At 12:02 p.m. another aide came to 'Table B' and sat next to a resident and offered her juice which she readily drank. The 2 other aides were observed just sitting there staring into space.	F 241	not been filled team members are expected to intervene and assist. Team members have been re-educated and are expected to assist with opening packages if the resident is unable to do so independently. e. Team members who assist residents in the dining been re-educated that residents shall be served food in a timely manner and should not be seated at the table without food or service for excessive periods of time. Team members will be educated to address and prevent any feeling of exclusion by a resident. Explanations about delays or other service issues will be addressed verbally by the team member to the resident. Follow up notice will be given when indicated to reassure the resident that their requests have been heard.	4/10/16

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F 241	Continued From page 7 At 12:03 p.m. an aide at 'Table B' finally offered a dependent resident juice and she drank without encouragement. The 3 aides sitting at 'Table B' made no attempt to make conversation or interact with the residents. Observation was made of 4 aides sitting at 'Table A' with residents who require total assist with meals and there was no interaction/communication with the residents. The aides were observed to be talking with each other across the table and over the residents. At 12:10 p.m. the 3 aides sitting at 'Table B' made no further attempts to offer fluids to the 3 of the 5 residents sitting there requiring total assist with their meals. Also observed was a resident at the next table 'Table C' trying to open a package of crackers with one hand. It was noted she had no use of her left arm, finally got the package open with her , dumped the crackers on the table cloth and started to eat them. At 12:11 p.m. a dietary aide brought soup to the resident sitting across from the resident at 'Table C' and did not offer the other resident any soup. The resident with no use of her left arm was now using a fork in her right hand to pry open another cracker package. Observation was made of 3 aides sitting at 'Table B' with the 5 residents and the ADON was observed to be mingling around the dining no staff member stopped by or observed the resident requiring assistance to open the cracker package. At 12:12 p.m. the ADON walked up to the resident with no use of her left arm and who was not offered soup at the same time as her table mate at 12:11 p.m. and asked her if she wanted soup to which she replied "I' d love some soup." During this interaction she was still trying to pry open the crackers with her fork and the ADON did not notice. Her table mate had already finished her soup and had her bowl removed from the	F 241	f. Team members who assist residents in the dining be re-educated that they must not talk over residents or talk across the table to each other and appear to disregard a resident's dignity at any time. g. If a resident has leg rest in their w/c, leg rests will be adjusted to allow resident to sit properly at the dining to prevent their legs from hanging freely. The DON or designee will conduct audits and monitor practices noted above five times a week for two months and then quarterly as determined by the QAPI committee to determine if the resolutions have been effective.	4/10/16

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F 241	Continued From page 8 table. At 12:14 p.m. the soup was brought to the resident and she said thank you and immediately started to eat. 'Table B' was observed to just receive their soup, 19 minutes after 'Table A' located right next to them. At 12:20 p.m. the soup was fed to 3 of the 5 residents at 'Table B' and completed. Three aides were observed sitting at the table not doing anything. There was no interaction with the residents and the residents were not offered juice or water while waiting on the lunch entree. At 12:30 p.m. the female resident at 'Table C' sitting across from the resident with no use of her left arm, was asked by a dietary aide what she wanted for lunch, showed her the menu, and the resident made her selection. The dietary aide totally ignored the other resident, did not ask her what she wanted for the main course, she just left the table. At 12:35 p.m. observation was made of another dietary aide going up to the resident at 'Table C' and ask her what she wanted for lunch. She placed her order at that time, 5 minutes after her table mate was asked. Her tablemate was then served her meal and finished before she received her lunch meal at 12:45 p.m. Additionally observed during the lunch meal on from 11:55 a.m. to 12:45 p.m. there were 10 female residents seated at tables who had their wheelchair legs removed so the wheelchair could be pushed up to the table. The wheelchair legs taken off were stored under their wheelchairs. It was observed their feet were dangling loosely down and their feet were not touching the floor. Two female residents were observed to be trying to feel around with their feet to find the table cross bar so they could rest their	F 241		4/10/16

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F 241	Continued From page 9 feet on them. Of note the 2 tables at the back right corner of the dining , identified as 'Table A' and 'Table B' by the window, are residents who require total assist or require assist with set up, are on puree diets and are . Review of the facility policy on Dignity states in part, 'Residents shall be treated with dignity and respect at all times; Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth; Staff shall treat residents with dignity and sensitivity.' 4) On 03/0715 at 11:32 AM, there were 29 Residents seated in the main dining the Banyan Unit. The Residents sitting at their tables had neither food or beverage served to them at 12:18 PM. On at 12:15 PM a random interview was conducted with a non-sampled, alert and oriented Resident. He was overheard telling a private duty Aide, "When is the food coming, I'm hungry." The Aide advised him that the food was coming. The Aide advised the surveyor that the lunch dining is supposed to begin at 11:30 AM everyday, but it never starts on time. On at 3:30 PM a review of the Resident Council minutes was conducted. The minutes showed that there were (12) Resident Council minute reports dating back to 2015. Of those reports reviewed, there were (5) months of complaints regarding the poor customer service experienced by the diners in the Banyan Hall dining . There was one complaint in 2015 from a resident that it takes a long time to get served in the Cypress dining . 5) Based on a confidential Resident interview	F 241	Any resident council meeting may disclose opportunities for improvement that should be acted upon by facility team members. It is the practice at Abbey Delray South to conduct monthly Resident Council metings to improve communication between the residents and the team members. The monthly Resident Council Meeting are where tne resicents can share experiences, concerns and make recommendation for how their care is organized and provided. The Resident Council meeting is recorded in it's minutes. The Resident Council meeting minutes may provide information about issues of concerns to our residents. The Activities Director will be re-educated to more closely monitor trends and issues in the Resident Council meetings and work with the Administrator or other departments to intervene with resolutions and report the resolution efforts at the next Resident Council meeting.	4/10/16

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F 241	Continued From page 10 conducted on at 3:20 PM, it was stated that the Resident is unhappy with the facility as the Resident has to wait an extended time for services with the nurses. The Resident states dining service is bad and unorganized. Resident sits and waits for long periods of time to be served, especially when she is hungry and wants to eat. Confidential Resident further states the staff have attitudes. This is the Resident's third admission to this facilty, and states this is the worst.	F 241	The Activities Director will monitor and report on trends in the Resident Council meeting minutes over the next 12 months and report monthly to the Administrator and at the QAPI Committee monthly and then quarterly as determined by the QAPI committee.	
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide foods prepared by methods that conserve nutritive value, flavor, and appearance. The findings included: During the kitchen/food service sanitation tour conducted in the main kitchen accompanied with the facility's administrator and executive chef on at 9:50 AM it was noted that 5 pans of cooked boneless chicken portion (approximately 100) were located within walk-in refrigerator #2. The chef stated that the chicken was pre-prepared for the lunch meal of	F 364	F 364 Nutritive, Value/Appearance/Palatability/Prefer Temp of food All residents in the Health Center are likely to be affected by a loss of nutritive value, appearance or palatability for any food prepared too far in advance. Dietary staff will be inserviced on use of standardized recipes for proper preparation. The Certified Dietary Manager or Clinical Dietician will inspect the menu and assess that no food is prepared more than 4 hours before meal service. The menu and food needed to fulfill the menu will be audited 5 times a week for three months to ensure that no food is prepared more than 4 hours in advance.	4/10/16

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F 364	Continued From page 11 Further interview conducted with the chef revealed that the chicken was prepared over 24 hours in advance and would require excessive reheating for the lunch meal of . Further interview revealed that the chef was unaware the excessive reheating and cooking of foods including poultry would result in a negative effect of the food nutritive content as well as appearance and palatability. Review of the standardized recipe for the preparation of the Chicken Creole revealed that there was no documented instructions to prepare the boneless chicken portions 24 hours in advance. During the observation of the lunch meal conducted on in the Ashley and Cypress dining it was noted that numerous residents did not eat the Chicken Creole and asked for an entree substitute. It was also noted during individual interviews, residents stated issues with the quality of foods being served.	F 364	Food Service Director or designee will conduct daily rounds to ensure use of standardized recipes. A report of the audit will be submitted to the Administrator on a daily basis, and a weekly summary report will be presented to QAPI Committee on a monthly baisis for three months and then quarterly or as determined by the QAPI committee.	4/10/16
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to store,	F 371	**F 371** **Food Procurement, Store/Prep/Serve-Sanitary** Abbey Delray South procures food from sources approved or considered satisfactory by Federal, State or local authorities. Abbey Delray South stores, prepares, distributes, and serves food under sanitary conditions. Residents receiving meal service could have been affected at the time of meal service during the survey.	

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F 371	Continued From page 12 prepare, distribute and serve food under sanitary conditions that include: 1) proper chemical concentration in the 3-compartment sink and cleaning cloth buckets, 2) proper convening of facial hair in food preparation and serving areas, proper refrigeration storage of potentially hazardous foods, 3) ensure hot foods are being held at regulatory temperatures. The findings included: A) During the kitchen/food service sanitation tour of the main kitchen conducted on at 9:30 AM accompanied with the administrator and executive chef, the following were noted: 1) Prior to the tour the executive chef was noted to be preparing foods. Further observation revealed that the chef's mustache and beard were not covered with the hair to ensure that foods were not contaminated with facial hair. 2) Chemical level tests were conducted by the executive chef of the 3-compartment sink, and cleaning rags buckets (3) to ensure that the chemical sanitizer met the regulatory requirement. The findings of the tests revealed excessive Quaternary chemical levels in the 3-compartment sink and cleaning rag buckets. The regulatory requirement of 200 PPM of the sanitizing agent was exceeded and recorded at over 400 PPM. There was a potential of chemical toxicity being left on the surfaces of cooking pots, pans, and utensils where foods are prepared and served. 3) During the observation of the walk-in refrigerator #2 it was noted that cooked and raw foods were being stored together on shelving.	F 371	The deficiency has 1. Culinary team members will be inserviced on using a hair when they have facial hair. 2. Culinary team members will be inserviced on chemical sanitizers to meet the regulatory requirement of 200 PPM. 3. Culinary team members will be inserviced on proper storage of raw foods and cooked food items. 4. Culinary team members will be inserviced on proper of disposal of unused breakfast food items. To clarify the sausage was not for the Health Center residents. 5. Culinary team members will be inserviced on taking temperatures of all hot/ food items prior to meal services.	4/10/16

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F 371	Continued From page 13 Specifically one storage shelf contained a pan of cooked hamburg patties (25) that was directly stored next to a box of raw catfish and another shelf contained 1 pan of cooked hamburg patties (25) that was directly stored next to containers of raw pork. 4) During the tour of the main kitchen it was noted that a pan of uncovered sausage was located in the main steam table. Staff identified that the sausage links was still being served for the breakfast meal. At the request of the surveyor the temperature of the sausage was taken with the facility's calibrated bayonet thermometer. The temperature of the sausage links was recorded at 96 degrees F which did not meet the regulatory required hot food holding temperature of 135 degrees F. 5) During the observation of the lunch meal conducted on at 11:30 AM in the Cypress satellite kitchen accompanied with the facility's Registered Consultant Dietitian it was noted that hot foods stored within the steam table were not being held at the regulatory required temperature of a minimum 135 degrees F. The hot foods were taken with the facility's bayonet thermometer and were recorded as follows: * Chicken Creole = 120 degrees F * Bahaman Vegetables = 110 degrees F * Sauteed Cabbage = 125 degrees F. * Soup = 130 degrees F * Fortified Cream Soup = 128 degrees F * Pureed Soup=125 degrees F * Baked Potato = 120 degrees F This deficiency have the potential to effect 89 of 89 facility residents.	F 371	Culinary Director or designee will conduct daily rounds to ensure proper usage of hair , ensure chemical sanitizers meet regulatory requirements, proper storage of raw & cooked food items, proper disposal of unused breakfast food items, and food temperatures. Findings will be reported monthly to the QAPI Committee and then quarterly as determined by the QAPI committee.	4/10/16

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F 441	Continued From page 14	F 441		
F 441 SS=D	483.65 CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of and (a) Control Program The facility must establish an Control Program under which it - (1) Investigates, controls, and prevents in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to (b) Preventing Spread of (1) When the Control Program determines that a resident needs isolation to prevent the spread of , the facility must the resident. (2) The facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the . (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	F 441 Control, PreventSpread, Linens It is the practice of Abbey Delray South to promote, establish, and maintain an Control Program designed to provide a safe, sanitary, comfortable environment and to help prevent the development and transmission of and . Residents receiving laundry service at the time observed could have been by the deficient practice during survey. In-serviced main laundry team member on the storage of their personal items within the Laundry and Linen areas. To ensure compliance random audits will be completed by the Director of Hospitality Services or designee 3 times a week for 8 weeks. Findings of the audit will be brought to QAPI committee monthly to identify any additional areas for improvement by the Director of Hospitality Services or designee and then quarterly or as determined by the QAPI committee.	4/10/16 4/10/16

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F 441	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to handle, store and process linens as to prevent the spread of as evidenced by personal belongings located on the clean linen folding table in the clean linen laundry The findings included: During a tour of the laundry area on at 10:30 AM, accompanied by the Director of Hospitality Services, several personal handbags (4) and opened bottled water were observed stored directly on the surface of the clean linen folding table in the clean linen storage area. On further observation it was noted that a soiled personal cell phone and cell phone charger were stored on the table surface in close proximity of the freshly laundered and folded clean facility linen: bed linens, table cloths, towels, etc. This had the potential of impacting the entire facility (89 Residents). During an interview with the Director of Hospitality Services on 10:40 AM, post laundry , it was confirmed that personal handbags and food and water are prohibited in the laundry area due to control issues. The Director of Hospitality Services further acknowledged that personal handbags and personal cell phones are considered dirty and should not be stored in the clean linen clean linen. The Director of Hospitality Services stated they have employee lockers in which the employees are required to store their belongings.	F 441		4/10/16

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F 441	Continued From page 16 Review of the facility's Departmental (Environmental Services) -Laundry and Linen protocol dated , 2010, it is documented, "The purpose of this procedure is to provide a process for the safe and handling, washing, and storage of linen."	F 441		4/10/16

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NAME OF PROVIDER OR SUPPLIER: ABBEY DELRAY SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 1717 HOMEWOOD BLVD, DELRAY BEACH, FL 33445

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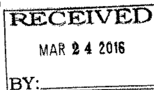
N 000	INITIAL COMMENTS An unannounced licensure survey was conducted on through at Abbey Delray South. The facility had deficiencies at the time of the visit.	N 000	The statements made on the Plan of Correction do not constitute admission of agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws.	
N 203 SS=E	400.022(1)(n), FS Right to be Treated with Dignity The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record reviews, it was determined that the facility staff failed to promote care in an environment in the dining ., meal service, and answering of call bells that maintains each residents dignity and respect in full recognition of his or her individuality. The findings included: 1) During the observation of the lunch meal on 03/07/16, breakfast and lunch meals on and , and breakfast meal on it was noted that dietary transport carts are placed in the hallways of the Cypress, Ashley , and Banyon resident units. Further observations revealed that many resident eat their meals in their own . Upon finishing their meals the CNA's remove the resident and scrape garbage/trash into bussing bins located on the transport carts, the soiled dishes are then stacked on the cart which is then covered only by a thin bed sheet. On numerous occasions the covering sheet had slipped off the carts exposing the garbage/trash and stacks of soiled dishes.	N 203	It is the practice of Abbey Delray South to promote and care for residents in a manner and in an environment that maintains or enhances each residents dignity and respect. Residents receiving tray service in their and all residents and others in the hallways may have been affected by the deficient practice at the time of the survey. Resident meal trays will no longer be bussed in the hallway. The used tray will be placed in a covered cart and then bussed in the kitchen area. New tray carts have been purchased to better serve the resident's needs, preserve the cleanliness in the hallways and facilitate the collection of meal trays removed from resident's	4/10/16

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James Ransone — TITLE: NHA — (X6) DATE: 3-23-16

STATE FORM 6899 4LIR11



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N 203	Continued From page 1 During the observations it was noted that numerous residents are moving about the main hallways and have to pass either the staff scraping the soiled dishes or pass the opened exposed garbage/and trash bins. Interview conducted with administrator on at 10:10 AM revealed that the busing of soiled resident dishes in the resident's main hallways has been going on for some time and was a resident dignity issues and would be addressed immediately. 2) A confidential interview was conducted with a residents on at 10:30 AM, the surveyor asked the resident if staff treated her with dignity and respect. The resident stated 50% of the staff have a bad attitude when providing care. On at 3:30 PM, the resident stated a (CNA) certified nursing assistant again had an bad attitude when providing care. The resident stated she did not want to report the staff because the staff may become upset with her. 3) Obseravations made on of the breakfast meal in the Banyan dining made to include: At 7:30 a.m. one table with 3 female residents was observed with one of the residents being fed oatmeal by an aide and the other 2 residents with no food in front of them. At 7:35 a.m. 6 tables with residents seated at the tables was observed with each table of residents being offered beverages, oatmeal and the main breakfast entre. At 7:45 a.m. 2 tables situated at the back right of the dining to the windows was observed to have no meal service as yet. One of	N 203	Dietary and team members will be educated on the new system. The Dietary Supervisor or Nursing Supervisor will monitor the tray removal process to ensure that the trays are covered and not bussed in the hallways. The Dietary or Nursing Supervisor or designee will conduct an audit of meal tray removal 5 times a week for two months and then a sample of 15 meal times for an additional two months to ensure that the tray cart is covered and that trays are not bussed in the hallways. The results of the audits will be reported to the DON and to the QAPI Committee for three months and then quarterly or as determined by the QAPI committee. 2. It is the practice of Abbey Delray to ensure that the resident is treated with dignity and respect. Abbey Delray South expects residents to be provided all levels of care in a manner that promotes a dignified experience and one where there is no fear of reprisal. This comment was shared related to a confidential interview. The person who communicated the complaint was not identified to Abbey Delray South team	4/10/16

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N 203	Continued From page 2 the tables seated 5 female residents, referred to as 'Table A' and the other table seated 4 female residents and 1 male resident, referred to as 'Table B'. At 7:54 a.m. a resident was brought in to the dining an aide and an attemp to place the resident at 'Table A' was made however there was no the 2 tables to pass through. The aide proceeded to move one female resident from 'Table B' out of the way and the new resident was placed at 'Table A' and then the female resident that was moved was placed back at 'Table B'. At 7:55 a.m. 3 aides were observed seated at 'Table A', then one more aide joined the table. The 4 aides were observed talking amongst themselves and not interacting with the residents. It was observed the residents of the 2 tables had glasses of thickened water in front of them however they were out of their reach and were not being offered a drink by the aides. At 8:00 a.m. 6 tables of residents were observed eating, however 'Table A' and 'Table B' had not been served as yet. At 8:03 a.m. 'Table A' was observed to be offered juice. There were now 5 aides seated at the same table one in between each resident making 10 cramped around the same table. At 8:05 a.m. 'Table B' had not been served as yet. At 8:09 a.m. at 'Table B' it was observed 3 of the female residents were sleeping. One female resident who was able to reach for items on the table was observed to be drinking out of coffee mug however no swallowing action was observed. The coffee mug was observed to be empty and the resident was going through the motion of drinking. The male resident at 'Table B' was observed to be staring over at 'Table A' which was now being served. It was observed that 4 residents were being fed oatmeal and one	N 203	members, therefore the staff was not given an opportunity to make a specific intervention. All residents have the potential to be by this stated deficiency. Team members will be reeducated about customer service skills and resident rights, which include the resident's right to voice a complaint without fear of reprisal. The DON or designee will conduct six resident and/or family interviews a week for three months to determine if the staff are demonstrating a professional attitude. The results of the audits will be presented to the QAPI Committee monthly for three months and then quarterly or as determined by the QAPI committee. 3. Residents in the dining were provided meals as soon as a delay was recognized. Residents who are served in the dining at risk from the same deficiency.	4/10/16

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N 203	Continued From page 3 resident did not receive anything. At 8:11 a.m. the 1 resident at 'Table A' that had nothing was now being served oatmeal and was being fed by an aide. At 8:15 a.m. a female resident at 'Table B' was observed to wake up. Another female resident at the table was observed to open a coffee creamer and drink the creamer. She drank 3 of the creamers then was observed to open up a of butter and with the end of a tablespoon ate the butter. The male resident at the table was observed to continue to stare at 'Table A' where the residents had received their food. At 8:17 a.m. the residents at 'Table A' were being fed oatmeal by the 5 aides sitting at the table. At 8:19 a.m. a female resident wheeled herself into the dining Immediately was offered cereal and juice by a dietary aide. At 8:22 a.m. the male resident of 'Table B' continued to look over at 'Table A' who were being fed oatmeal then he was observed to look down at his table and then back at the table that had food then back at his table. His table had not been offered food as yet. At 8:24 a.m. 'Table B' still had no food offered. It was also observed there was no interaction of the numerous staff members with the residents as the staff were milling around the dining . It was observed that no staff were paying any attention to this table with no food. At 8:25 a.m. an aide came to 'Table sat next to the male resident between him and the sleeping female resident. There was still no food at the table and no effort by the aide to initiate the meal service. At 8:26 a.m. the main breakfast entree was observed to be served to 2 residents at 'Table A', then another plate of food was brought over making 3 of the 5 residents seated at the table with food and 2 residents without food. The male	N 203	The Dining and licensed nursing team members will monitor, respond and report occurences where a resident is left at the dining table without food for too long. Team members will intervene as necessary to improve the timeliness of food service delivery. The Dining will ensure that tables are placed in their proper locations before meal service is started to prevent inadequate space for resident chairs, and wheelchairs and to ensure ease of movement to and from a table in the dining table. Table placement will be arranged by the Dining in the Health Center to provide for resident movement. The table placement will be audited five times a week for two months and then five times monthly for two additional months and the findings reported to the QAPI Committee each month and then quarterly or as determined by the QAPI committee. It is the practice at Abbey Delray South that staff communicates effectively and with residents and guests in the dining make the dining experience pleasant and enjoyable.	4/10/16

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	95052	A. BUILDING: ______ B. WING ______	

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N 203	Continued From page 4 resident at 'Table B' was observed to now be staring nonstop at 'Table A' who had been served their breakfast. At 8:30 a.m. the dietary aide was observed to be milling around the dining . There was no interaction observed with 'Table B'. The aide that sat down at 'Table B' at 8:25 a.m. got up and went to assist another resident with her breakfast at another table. At 8:31 a.m. another aide came to 'Table B' and sat down between the male resident and the sleeping female resident. The aide was observed to offer the sleeping resident water and she took it. The female resident that was observed at 8:09 a.m. to be drinking from an empty coffee mug continued to drink out of the empty coffee mug. Nobody was observed to offer her a beverage. At 8:32 a.m. a nurse identifying herself as the floor RN on the Banyan unit went to 'Table B' talked to the aide sitting there, then turned around and left. There was still no food offered at 'Table B'. The male resident continued to look over at 'Table A' where they were well into their breakfast meal and then look down at his table where there was no food. Additionally it was noted that the male resident, despite having a glass of thickened water with a straw with the paper still on it, in front of him, did not attempt to reach for the glass and no aide who came and went from the table offered any resident anything to drink. At 8:35 a.m. the aide continued to sit in the same spot with no interaction between her and the residents. A ambulatory male resident was observed to enter the dining as he sat down at a table was immediately offered breakfast by a dietary aide. At 8:36 a.m. the aide seated at 'Table B' got up and left. The male resident at 'Table B' continued to keep looking over at 'Table A' who were being fed breakfast.	N 203	Team members who were deficient in this practice were advised to correct their behavior as it was made known to management during the survey. Residents who dine in the dining at risk for the same deficiency. a. Team members will be re- educated in proper procedures and behaviors expected in the Dining . A comprehensive customer service program will be conducted and will include focusing on residents in conversations in the dining . b. Nursing and culinary team members who work in the dining be re- educated about procedures expected in the Dining . Residents who have beverages will have the beverage placed within their reach and assisted as appropriate. c. The Culinary Manager will be re-educated to observe excess residents are not placed at one table at any given time.	4/10/16

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N 203	Continued From page 5 At 8:40 a.m. the same aide came back to 'Table B' and sat down in the same spot as she sat before. At 8:42 a.m. another aide came to 'Table B' and sat down between 2 female residents. The Assistant Director of Nursing (ADON) was observed to come up to the table and say to the 2 aides that 'these residents need encouragement' and she was then overheard to say as she looked at the resident's table "Oh, no food" then proceeded to walk away. At 8:43 a.m. another aide came to 'Table B' and sat down next to the male resident, making a total of 3 aides now seated at the table, and she proceeded to put a clothing protector on him. She then proceeded to take the paper covering off of the straw in his water glass and offer him a drink of water which he readily took. The other aide sitting between the male resident and the sleeping female resident offered the sleeping resident water and she opened her eyes and took a sip. At 8:45 a.m. the ADON was observed sitting at the 'Table A' assisting a resident with feeding. At 8:47 a.m. a dietary aide came to 'Table B' and for the first time offered the residents juice. A glass of juice was put in front of the female resident who drank the coffee creamers and ate the , ... of butter at 8:15 a.m. and she said to the dietary aide "Thank you" and immediately started to drink, took a sip, put the glass down, picked it up again and took another sip and continued to do this until the juice was almost all gone. At 8:50 a.m. a dietary aide came to 'Table B' and said to the 3 aides sitting there "Are you ready?" At 8:51 a.m. the resident that drank the coffee creamer was brought a bowl of oatmeal and she immediately started eating it without adding milk or sugar. 'Table B' was not offered/brought food for 1 hour and 19 minutes while all other	N 203	Consideration will be given to the number of residents at a table, residents needing assistance and the impact of team members and equipment that may crowd the area. d. Team members will be re-educated regarding residents with limitations on their ability to effectively manage beverages, food and condiments. When such issues occur because of the residents limitations, interventions will be offered. If a resident is attempting to take a beverage glass that has not been filled team members are expected to intervene and assist. Team members have been re-educated and are expected to assist with opening packages if the resident is unable to do so independently. e. Team members who assist residents in the dining been re-educated that residents shall be served food in a timely manner and should not be seated at the table without food	4/10/16

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N 203	Continued From page 6 residents in the dining eating or were done eating. At 8:52 a.m. the male resident at 'Table B' was brought oatmeal and the aide put sugar and milk in it and offered it to him. He eagerly ate without encouragement. On at 11:54 a.m. a lunch observation was conducted in the Banyan dining the same vantage point. Observation was made of the same 2 tables, 'Table A' which had 5 female residents seated at it and 'Table B' who also had 5 females seated at it without the male resident present. At 11:55 a.m. beverages were observed placed in front of the 5 female residents at 'Table B'. It was observed that 3 of the 5 female residents could not help themselves and required total assist with eating. Observation was made of 2 female residents sitting at the next table against the wall and one resident was brought soup but not the other. At 11:57 a.m. 2 aides were observed sitting at 'Table B' next to the 2 female residents who required assistance and they were not offering them juice or another beverage. They were observed to be just sitting there not interacting with the residents. At 12:02 p.m. another aide came to 'Table B' and sat next to a resident and offered her juice which she readily drank. The 2 other aides were observed just sitting there staring into space. At 12:03 p.m. an aide at 'Table B' finally offered a dependent resident juice and she drank without encouragement. The 3 aides sitting at 'Table B' made no attempt to make conversation or interact with the residents. Observation was made of 4 aides sitting at 'Table A' with residents who require total assist with meals and there was no	N 203	or service for excessive periods of time. Team members will be educated to address and prevent any feeling of exclusion by a resident. Explanations about delays or other service issues will be addressed verbally by the team member to the resident. Follow up notice will be given when indicated to reassure the resident that their requests have been heard. f. Team members who assist residents in the dining be re-educated that they must not talk over residents or talk across the table to each other and appear to disregard a resident's dignity at any time. g. If a resident has leg rest in their w/c, leg rests will be adjusted to allow resident to sit properly at the dining to prevent their legs from hanging freely.	4/10/16

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N 203	Continued From page 7 interaction/communication with the residents. The aides were observed to be talking with each other across the table and over the residents. At 12:10 p.m. the 3 aides sitting at 'Table B' made no further attempts to offer fluids to the 3 of the 5 residents sitting there requiring total assist with their meals. Also observed was a resident at the next table 'Table C' trying to open a package of crackers with one hand. It was noted she had no use of her left arm, finally got the package open with her [illegible], dumped the crackers on the table cloth and started to eat them. At 12:11 p.m. a dietary aide brought soup to the resident sitting across from the resident at 'Table C' and did not offer the other resident any soup. The resident with no use of her left arm was now using a fork in her right hand to pry open another cracker package. Observation was made of 3 aides sitting at 'Table B' with the 5 residents and the ADON was observed to be mingling around the dining [illegible] no staff member stopped by or observed the resident requiring assistance to open the cracker package. At 12:12 p.m. the ADON walked up to the resident with no use of her left arm and who was not offered soup at the same time as her table mate at 12:11 p.m. and asked her if she wanted soup to which she replied "I' d love some soup." During this interaction she was still trying to pry open the crackers with her fork and the ADON did not notice. Her table mate had already finished her soup and had her bowl removed from the table. At 12:14 p.m. the soup was brought to the resident and she said thank you and immediately started to eat. 'Table B' was observed to just receive their soup, 19 minutes after 'Table A' located right next to them. At 12:20 p.m. the soup was fed to 3 of the 5 residents at 'Table B' and completed. Three	N 203	The DON or designee will conduct audits and monitor practices noted above five times a week for two months and then quarterly as determined by the QAPI committee to determine if the resolutions have been effective.	4/10/16

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N 203	Continued From page 8 aides were observed sitting at the table not doing anything. There was no interaction with the residents and the residents were not offered juice or water while waiting on the lunch entree. At 12:30 p.m. the female resident at 'Table C' sitting across from the resident with no use of her left arm, was asked by a dietary aide what she wanted for lunch, showed her the menu, and the resident made her selection. The dietary aide totally ignored the other resident, did not ask her what she wanted for the main course, she just left the table. At 12:35 p.m. observation was made of another dietary aide going up to the resident at 'Table C' and ask her what she wanted for lunch. She placed her order at that time, 5 minutes after her table mate was asked. Her tablemate was then served her meal and finished before she received her lunch meal at 12:45 p.m. Additionally observed during the lunch meal on from 11:55 a.m. to 12:45 p.m. there were 10 female residents seated at tables who had their wheelchair legs removed so the wheelchair could be pushed up to the table. The wheelchair legs taken off were stored under their wheelchairs. It was observed their feet were dangling loosely down and their feet were not touching the floor. Two female residents were observed to be trying to feel around with their feet to find the table cross bar so they could rest their feet on them. Of note the 2 tables at the back right corner of the dining , identified as 'Table A' and 'Table B' by the window, are residents who require total assist or require assist with set up, are on puree diets and are Review of the facility policy on Dignity states in part, 'Residents shall be treated with dignity and respect at all times; Treated with dignity means	N 203		4/10/16

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N 203	Continued From page 9 the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth; Staff shall treat residents with dignity and sensitivity.' 4) On at 11:32 AM, there were 29 Residents seated in the main dining the Banyon Unit. The Residents sitting at their tables had neither food or beverage served to them at 12:18 PM. On at 12:15 PM a random interview was conducted with a non-sampled, alert and oriented Resident. He was overheard telling a private duty Aide, "When is the food coming, I'm hungry." The Aide advised him that the food was coming. The Aide advised the surveyor that the lunch dining is supposed to begin at 11:30 AM everyday, but it never starts on time. On at 3:30 PM a review of the Resident Council minutes was conducted. The minutes showed that there were (12) Resident Council minute reports dating back to 2015. Of those reports reviewed, there were (5) months of complaints regarding the poor customer service experienced by the diners in the Banyan Hall dining . There was one complaint in 2015 from a resident that it takes a long time to get served in the Cypress dining . 5) Based on a confidential Resident interview conducted on at 3:20 PM, it was stated that the Resident is unhappy with the facility as the Resident has to wait an extended time for services with the nurses. The Resident states dining service is bad and unorganized. Resident sits and waits for long periods of time to be served, especially when she is hungry and wants to eat. Confidential Resident further states	N 203	Any resident council meeting may disclose opportunities for improvement that should be acted upon by facility team members. It is the practice at Abbey Delray South to conduct monthly Resident Council metings to improve communication between the residents and the team members. The monthly Resident Council Meeting are where the residents can share experiences, concerns and make recommendation for how their care is organized and provided. The Resident Council meeting is recorded in it's minutes.	4/10/16

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N 203	Continued From page 10 the staff have attitudes. This is the Resident's third admission to this facilty, and states this is the worst. Class III	N 203	The Resident Council meeting minutes may provide information about issues of concerns to our residents. The Activities Director will be re-educated to more closely monitor trends and issues in the Resident Council meetings and work with the Administrator or other departments to intervene with resolutions and report the resolution efforts at the next Resident Council meeting. The Activities Director will monitor and report on trends in the Resident Council meeting minutes over the next 12 months and report monthly to the Administrator and at the QAPI Committee monthly and then quarterly as determined by the QAPI committee.	4/10/16

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Abbey Delray South
1717 Homewood Blvd
Delray Beach, FL 33445

Dear Administrator:

On , 2016- , 2016, Recertification, Licensure and Life Safety Code surveys were conducted in your facility by representatives of this office.

The purpose of this visit was to determine if your facility was in compliance with requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found not in substantial compliance with the participation requirements.

Enclosed are the provider's copies of Form CMS-2567 (Statement of Deficiencies and Plan of Correction) and State (3020) Form. These forms reference the deficiencies that were identified during the visit.

You will not receive a copy of this letter and attachments in the mail; you will only receive this faxed report.

A Plan of Correction (POC) for the deficiencies must be submitted to this Field Office 10 days after your facility receives the faxed Form CMS-2567. Failure to submit an acceptable POC within ten (10) days after receipt of the faxed statement of deficiencies may result in the imposition of remedies. You will be notified by telephone or fax if your POC is found to be acceptable. If your POC is found to be unacceptable, you will be informed in writing. The correction date indicated by the facility shall be after the date of survey exit. **Deficiencies shall be corrected no later than , 2016.**

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Recommended Remedies:

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, we will provide you with a separate formal notification of that determination.

Remedies will be recommended for imposition by CMS if your facility has failed to achieve substantial compliance by the revisit. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the noncompliance found may result in a change in the remedy recommended. When this occurs, you will be advised of any change in remedy.

- Civil Money Penalty, in an amount and duration to be determined by CMS.
- A mandatory denial of payment for new admissions will be imposed **, 2016** if substantial compliance is not achieved by that time.
- Termination of Medicare Agreement. We are recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **10, 2016** if substantial compliance is not achieved by that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, the CMS Regional Office or State Medicaid Agency will impose the other remedies indicated above, or a revised remedy, if appropriate.

Informal Dispute Resolution:
In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Attention: IDR Coordinator
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 9-A
Tallahassee, Florida 32308
FAX (850) 414-6946
or
Phone number: (850) 412-4301
IDRCoordinator@ahca.myflorida.com

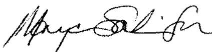
The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged

and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representatives. If you have questions, please contact this office at (561) 381-5840.

Sincerely,



Arlene Mayo-Davis
Field Office Manager

AMd/dmb

R6WB