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
	AL11966386	A. BUILDING: _____ B. WING _____	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITION OF THE PALM BEACHES	4880 LORING DRIVE WEST PALM BEACH, FL 33417

(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 Complaint survey, #2026001254, was conducted at Tradition of the Palm Beaches from through . The facility had deficiencies at the time of the survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice,	A 010		

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A 010	Continued From page 1 and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and,	A 010		

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A 010	Continued From page 3 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are	A 010		

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A 010	Continued From page 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a Resident Health Assessment (AHCA 1823 form) was completed upon admission to the facility and failed to re-assess for continued admission appropriateness based on health status changes and care needs, for 1 of 1 sampled residents (Resident # 2) who resided on the memory care unit, identified as a risk and experiencing multiple . The findings include: Review of Resident #2 Assessment form dated indicated the resident had medical diagnosis including 's , , undifferentiated , , and , . The resident was assessed to be independent with ambulation/ transferring and an elopement risk. Resident #2 required assistance with bathing, , and toileting. Review of the progress notes for Resident#2 indicated the resident was residing in an Assisted Living Facility (ALF) Memory Care Unit. The notes revealed the resident was observed to be constantly ambulating and had developed on her requiring treatment. Resident #2 was documented as verbally and physically aggressive towards staff. Resident#2's family was offered and accepted a transfer to a sister ALF facility located on the same campus, which provided more luxurious accommodations and amenities. Resident #2 was transferred to the new memory care facility on on grounds (new admission) and discharged from the previous ALF located on grounds.	A 010		

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A 010	Continued From page 5 Review of both facilities license number and credentials revealed each hold their own separate ALF license status. Although, both are located on the same campus each facility is its own entity for licensure purposes with the Agency. Review of the progress notes for Resident#2 indicated on the resident was observed walking in hallway, leaning to her right side. The note indicated that Resident#2 is a high risk. The resident is unable to stand straight, refused to sit down, and the nurse was unable to take her vital signs for assessment. The physician is notified, and the resident is sent to the hospital for evaluation. The resident returns the same day diagnosed with Ataxic gait and , wax. Review of the physician note dated indicated Resident #2 ambulates independently, denies any , , and has no new . The note indicates that the resident remains a risk due to her age, gait, and multiple . Further view of Resident #2's record indicated no new Resident Assessment form (AHCA form 1823) was completed for review of appropriateness on admission to the new facility location. Review of the progress notes for Resident#2 indicated on Resident #2 has episodes of . The physician is notified and orders, and lab work, this is declined by the family. Review of the progress notes for Resident#2 indicated on the resident is observed leaning to the right side. The resident's family is notified and instructs staff not to send the resident out to the hospital. Further notes indicated the	A 010		

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A 010	Continued From page 6 resident was verbally and physically aggressive towards staff during her Activity of Daily Living (ADL) care. Review of the progress notes for Resident#2 indicated on the resident is complaining of severe left sided , . She is observed shaking and intermittently screaming her discomfort. The nurse assesses the resident to have no redness, , or noted. The physician is notified and , are ordered. The family on notification refuses the ordered tests and is documented as stating "she is probably fine, and it is unnecessary and will cost too much". The family instructed the nurse to put cannabidiol (CBD) cream on the area. Review of the progress notes for Resident#2 indicated on the resident is observed ambulating on the 1st floor and then is found on sitting on the floor. Resident#2 is noted to be able to stand and take few steps. She is observed to grimace while ambulating with an unsteady gait and limp, holding her left side of , , and complaining of , in left . The resident after the . The physician is notified, , are ordered, along with , medication. The family is notified and refuses , and instructs the nurse not to send resident out to hospital. The note further indicates that the resident speaks directly with the family and states she was having , . The family then agrees to complete , only. , are ordered, including , , , and ankles and results show no injury. Review of the progress notes for Resident#2 indicated on the resident was observed ambulating and leaning to her right side. She is placed in a wheelchair for safety but refuses to	A 010		

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A 010	Continued From page 7	A 010		

stay seated. The resident stands, losing her balance and falling to floor in the hallway, hitting the of her . The family is notified and refuses to send the resident to the hospital for evaluation. Approximately one hour later, Resident #2 has another , and is found on the floor in the hallway. The note indicated that both are unwitnessed by staff.

Reviewed of facility incident reports dated at 12:37 PM revealed Resident #2 was sitting in her wheelchair yet refused to stay seated. She was found on the floor and assessed with a small bump on of her . The resident has no complaints about after injury. The physician is notified, along with the family who refused transport to the hospital for evaluation. Review of the second incident report indicates on at 1 PM Resident #2 sustained another unwitnessed when found sitting on the floor. The family is again notified and refuses to transfer to hospital for evaluation.

Review of the progress notes dated at 11:55 AM indicated the resident is observed after breakfast, and appeared weak, unable to stand or walk and continued to lean to the right side. The nurse documents that Resident #2 has noticeable change in her response to conversation. The physician is notified and orders the resident to be sent to the hospital for evaluation. The family is notified and expresses no need for transfer," probably the " and demanded to speak with EMT personnel. Family denied transport. The resident is monitored by staff every 15 minutes and documents the resident eating dinner meal and wheeling herself in hallway.

Review of the progress notes for Resident#2

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A 010	Continued From page 8 indicated on at 7:10 PM the resident is found on activity room floor; she can move all extremities and expresses no , . A is noted on her right . The resident has another episode of brown . The physician and family are notified and the physician orders 911 transfer to the hospital for evaluation. Review of the progress notes for Resident#2 indicated on phone calls were made between the facility and hospital revealing Resident #2 was diagnosed with a and severe , . Review of hospital records for Resident #2 dated indicated the diagnosis of "a large acute on hematomas with severe effect." Resident #2 was transferred to an acute care setting for treatment of the condition. The Institute of Health definition of acute-on- hematoma (SDH) is a fresh that occurs within a pre-existing, older collection on the 's surface. It typically affects older adults and those on , often following seemingly minor . This condition occurs in two distinct stages: The Phase: A slow occurred weeks or months ago, creating a fluid-filled, dark of over the . The Acute Phase: A new, fresh (often from minor or shifting ,) pools directly into that pre-existing . Symptoms often start gradually with the phase-like mild or a lingering -but worsen suddenly when the new occurs. Such as sudden, severe	A 010		

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A 010	Continued From page 9 , worsening or , numbness, or , (often on one side of the body), slurred speech or difficulty walking, and and . In an interview with Staff #A on 6 /15/26 at 2:30 PM she stated she works the day shift and had cared for Resident #2. She stated that the resident was physically aggressive when staff attempted to provide care for her. Staff #A stated that Resident#2 was a known risk, she had a history of since she would constantly ambulate throughout the facility, the hallways and refused to sit still in the activity area. Staff #A stated Resident #2 was very active/mobile and required extra monitoring by staff. In an interview with the DON on at approximately 2 PM he stated that he was hired after Resident #2 was initially admitted to the unit. He stated that Resident #2 was ambulatory and very mobile. The resident would throughout the entire unit by herself; she would not remain in the activity area for staff to have direct visual supervision. He acknowledged that the facility structural design requires additional staff monitoring of residents. The DON stated that Resident #2 was a risk and had history of . He stated that the family had denied the resident's transfer to the hospital for evaluation after on multiple occasions. The DON stated that he was unable to locate the resident's 1823 Assessment form from admission and found no assessments/ interventions implemented for continued residency. He stated that Resident #2's family had been offered and agreed to the residents' relocation and were aware of the unit's design challenges. He stated that the majority of residents are not as mobile as Resident#2 and	A 010		

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A 010	Continued From page 10 staff keep the residents in activities to provide supervision. He stated that the facility does not provide 1:1 supervision, the family would need to hire a private sitter. During a tour of the facility's Memory care unit on .. at approximately 2 PM, the locked memory care unit encompasses 2 floors. On the first floor, there are resident rooms located in one hallway, the hallway has angles, limited visual access from the nurse's station window. On the second floor, there are two hallways with numerous resident rooms on each side, the hallways have multiple angles, due to the building structural design, which prevents staff from providing direct visual access to monitor residents. In a confidential interview conducted on , concerns were expressed with the lack of visual availability to monitor residents ambulating in the facility 's hallways and common areas. The interviewee stated that the current design was not an ideal design, compared to an open floor plan design. The facility's design requires staff to constantly provide physical monitoring of numerous residents' whereabouts. Resident #2 ambulated throughout the facility freely,she a known risk with a history of unwitnessed and required additional staff supervision to monitor her. Class III	A 010		