STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105067	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulevard Rehabilitation Center	2839 S Seacrest Blvd Boynton Beach, FL 33435

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on observation, interview, and record review, the facility failed to provide assistance with dining in a manner to maintain dignity for 2 of 32 residents in the final sample (Resident #387 and #388). The findings included: 1. Record review revealed Resident #388 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had severe cognitive impairment and was dependent for activities of daily living. An observation of Resident #388 was conducted on 02/24/25 at 12:15 PM during lunchtime. Resident #388 was observed sitting up in a wheelchair next to his bed. A bedside table was noted between the resident and the resident's bed with a lunch tray on top. Staff Z, a Certified Nurse Assistant (CNA), was observed standing and leaning over the front of the resident, feeding the resident. 2. Record review revealed Resident #387 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had moderate cognitive impairment and required substantial/maximum assistance with activities of daily living. An observation of Resident #387 was conducted on 02/24/25 at 12:30 PM during lunchtime. Resident #387 was observed in bed. Staff Z, a Certified Nurse Assistant (CNA), was observed standing next to the resident, feeding the resident. An interview was conducted on 02/27/25 at 12:00 PM with the Director of Nursing (DON). The DON acknowledged staff should not be standing while assisting residents with meals.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on observation, interview, and record review, the facility failed to care plan dentures for 1 of 1 resident reviewed for dental (Resident #34); Failed to implement a care plan for dialysis for 1 of 3 residents reviewed for dialysis (Resident #387); and Failed to implement interventions for behaviors during dining for 1 of 30 residents who eat lunch in the [NAME] Dining Room (Resident #66). The findings included: 1. Record review revealed Resident #34 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident was cognitively intact and was dependent for activities of daily living. The assessment further documented no dental concerns for the resident. An observation and interview with Resident #34 was conducted on 02/25/25 at 10:00 AM. The resident was observed without teeth or dentures. Resident #34 stated she needed dentures. A review of Resident #34's care plan did not identify the resident's need for dentures. An interview was conducted with the Social Services Director (SSD) on 02/27/25 at 11:00 AM. The SSD stated the resident's dentures were at the resident's bedside. The SSD acknowledged there was no care plan for the resident's dentures. 2. Record review revealed Resident #387 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had moderate cognitive impairment, required substantial/maximum assistance with activities of daily living. The assessment further documented the resident received dialysis services. A review of Resident #387's care plan revealed a care plan for dialysis therapy. An intervention included to observe access site prior to leaving and upon return to facility from dialysis. Further review of Resident #387's record did not reveal any documentation of the resident's access site condition prior to leaving and upon return to facility from dialysis. An interview was conducted with the Unit Manager (UM) on 02/27/25 at 12:00 PM. The UM acknowledged the above. 50895 3. A record review of Resident #66 revealed that she was admitted to the facility on [DATE]. Her diagnoses included Morbid Obesity, Dementia, Unspecified Severity, With Other Behavioral Disturbance, and Cognitive Communication Deficit. Resident #66 ate lunch meals most days in the [NAME] dining room. According to an interview with the DON on 02/26/25 at 4:15 PM, the [NAME] Dining Room was used by residents who required supervision, and by residents who required assistance with feeding. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #66's care plan for psychotropic medications included a goal to remain free of behavioral impairment through the next review date. The care plan was last revised on 01/23/25, and it listed an intervention to redirect the resident if there were behaviors during meals. The staff failed to redirect Resident #66 when she ate food from Resident #92's plate on two observations during the lunch meal. A record review revealed Resident #92, was admitted to the facility on [DATE]. His diagnoses included: Hemiplegia and Hemiparesis following Cerebral Infarction affecting the right dominant side, and Dementia. The brief interview for mental status score noted on the Minimum Data Set assessment dated [DATE] was 11. This indicated that Resident #92 had moderate cognitive impairment. In addition, the assessment noted that Resident #92 spoke clearly and was able to understand and to make himself understood. During an observation on 02/24/25 at 12:23 PM, Resident #66 ate her portion of apple pie, and then she ate all of the apple pie filling from Resident #92's plate of apple pie. Only the crust of the pie remained on Resident #92's plate. During an observation on 02/26/25 at 12:33 PM, Resident #66 ate from Resident #92's fruit cup. Resident #92 watched Resident #66 as she ate his food, and he moved the fruit cup closer to his main meal plate. Resident #66 moved the fruit cup closer to her and she ate more of his fruit dessert. Resident #92 again pulled his fruit cup closer to his meal plate. The fruit cup was pulled back and forth between the two residents three times. After that, Resident #92 picked up his fruit cup dessert and attempted to drink from the fruit cup. The surveyor informed the resident that the staff will bring him a new fruit cup because Resident #66 already ate from the cup. The Physical Therapy Manager (PT Manager) was close by in the dining room. The surveyor told the PT Manager that Resident #66 ate from Resident #92's fruit cup and requested that she locate another fruit cup for Resident #92. Approximately five to ten minutes later, the PT Manager returned from the kitchen, and she served Resident #92 another fruit cup. After Resident #92 finished his lunch, he waved his hand to the surveyor and said thank you. An interview with the PT Manager on 02/26/25 at 3:40 PM revealed that she had no knowledge of the behavior exhibited by Resident #66 happening in the past.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on observation, interview, and record review, the facility failed to ensure a resident's wheel chair was maintained in a manner to prevent a skin tear to 1 of 5 residents reviewed for accidents (Resident #388). The findings included: Record review revealed Resident #388 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had severe cognitive impairment and was dependent for activities of daily living. An observation of Resident #388 was conducted on 02/25/25 at 11:00 AM. Resident #388 was sitting in a wheel chair (WC) in a lounge area with his significant other (SO). The resident was observed with a skin tear on the left outer calf area, that was bleeding. The resident's SO stated she had just noticed the area. Further observation revealed a tear on the resident's left leg rest of the WC, that was directly adjacent to the resident's fresh skin tear. Further observation of the tear on the resident's WC leg rest revealed the area was rigid and jagged. The resident's SO acknowledged the area and stated the resident had fragile skin. An observation was conducted with Staff K, a Licensed Practical Nurse (LPN), of Resident #388 with his SO outside on the patio area. The resident was observed with a dressing to the outer calf area. Resident #388's WC leg rest was still noted with the jagged tear directly adjacent to the resident's dressing on the left leg. Staff K acknowledged the torn, jagged area on the resident's WC left leg rest, and stated she would have therapy switch out the WC.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on observation, interview, and record review, the facility failed to identify a resident with a urinary catheter, and failed to obtain urology consult as ordered for 1 of 2 residents reviewed for urinary catheter (Resident #58). The findings included: Record review revealed Resident #58 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had mild cognitive impairment and required substantial/maximum assistance with activities of daily living. The assessment further documented the resident had an indwelling urinary catheter. A review of Resident #58's care plans revealed a care plan for resistive to care at times (dated 12/23/24 as resolved). Resident has an indwelling catheter but refuses to use the collection bag. He is clamping the tube and goes to the toilet to empty his bladder. A review of Resident #58's orders revealed an order dated 12/04/24 for a Urology follow up. An order dated 12/20/24 documented to discontinue Foley Catheter (urinary catheter), and reinsert if resident has not voided in 6 hours and notify physician. Further review of Resident #58's orders did not reveal a current order for a urinary catheter. A review of resident #58's Treatment Administration Record (TAR) revealed the resident refused for the urinary catheter to be discontinued on 12/20/24. There was no documentation of the physician being notified at the time the resident refused treatment. Further review of Resident #58's record did not reveal a urology consult was initiated for the resident. An interview was conducted with Resident #58 on 02/24/25 at 10:00 AM. The resident stated he had a urinary catheter that he takes care of himself. An interview was conducted with Staff Y, a Certified Nurse Assistant (CNA) on 02/26/25 at 11:30 AM. Surveyor questioned Staff Y if Resident #58 had a urinary catheter. Staff Y stated the resident did not have a urinary catheter. An interview was conducted with Staff L, a Licensed Practical Nurse (LPN) on 02/26/25 at 11:40 AM. Surveyor questioned Staff L if Resident #58 had a urinary catheter. Staff L stated the resident did not have a urinary catheter. Staff L went to observe Resident #58 and confirmed the resident did have a urinary catheter.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on observations, interviews and record reviews, the facility failed to follow physician orders to not take blood pressure (BP) on dialysis access extremity for 3 of 5 residents (Resident #128, Resident #442, and Resident #387); and failed to have an order for dialysis for Resident #387. The findings included: A record review of a facility document titled, Nursing Facility Dialysis Agreement, dated 10/30/2017, revealed under Control of Care, that the medical management of the Nursing Facility's residents will be under the direction of the resident's attending physician. Section D under Care of Access Site, revealed that Nursing Facility will cooperate in monitoring and caring for each resident's access site including: 1. Avoidance of blood pressure readings, venipuncture, and trauma in dialysis access extremity; and 2. Evaluation of patency of dialysis access including but not limited to shunts, and fistulas. 1. Record review revealed Resident #128 was admitted on [DATE] with diagnoses that included End Stage Renal Disease. A review of Minimum Data Set (MDS) assessment dated [DATE], Section C revealed a Brief Interview for Mental Status (BIMS) score of 11 indicating fair mental cognition. A review of orders revealed dialysis, arterio-venous (AV) fistula, right arm; monitor dialysis site for signs and symptoms of infection and check for thrill & bruit. A review of nursing care plan dated 01/30/25 included an intervention for no blood pressures or blood draws in right arm. Further review of resident's electronic health record revealed that Resident #128's BP was manually taken from the right arm on these dates and times between 2/15/25 - 2/26/25: On 2/15/25 at 10:06 AM; on 2/16/25 at 4:35 PM, and 7:58 PM; on 2/17/25 at 1:08 AM, 8:48 AM, and 6:26 PM; on 2/18/25 at 9:10 AM; on 2/19/25 at 9:33 AM, and 5:32 PM; on 2/20/25 at 2:38 AM, and 9:20 AM; on 2/21/25 at 0:08 AM, 1:22 PM, and 4:52 PM; on 2/22/25 at 9:17 AM; on 2/23/25 while standing at 1:30 PM; on 2/24/25 at 2:35 AM, 8:37 AM, and 3:58 PM; on 2/25/25 at 8:28 AM, and 2:22 PM; and on 2/26/25 at 11:31 AM, and 4:41 PM. Most of the BP readings were taken by Staff A, Registered Nurse (RN), and Staff H, Licensed Practical Nurse (LPN). 2. A record review revealed Resident # 442 was admitted on [DATE] with diagnoses including End Stage Renal Disease. A review of the admission MDS assessment dated [DATE], Section C revealed it was in progress. A review of physician orders dated 02/21/25 revealed Dialysis, no BP in right arm, every shift. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan initiated on 02/21/25 by Staff H, LPN, included an intervention of no blood pressures or blood draws in right arm. During a record review of Resident #442's electronic health record, it was revealed that during these dates and times, the blood pressure was taken on the right arm by Staff H, LPN: on 02/22/25 at 8:38 AM; on 02/23/25 at 7:59 PM; on 2/24/25 at 8:36 AM and 3:57 PM; on 2/25/25 at 8:14 AM, and 2:15 PM; and on 02/26/25 at 4:27 PM. In an interview with Staff I, RN, on 2/26/25 at 8:48 AM, who when asked regarding the care of a resident on dialysis, responded, I make sure I check for bruit on AV shunt/fistula, and I do not take BP on the resident's dialysis access arm. He added that he verifies the physician orders for dialysis, checks the orders for the location of the shunt/fistula, and documents in progress notes where he takes the BP. In an interview with Staff A, RN, on 02/27/25 at 8:58 AM, who stated she has been working in the facility for 8 years, and who when asked about dialysis care of a resident, responded that, I check for the dialysis order. I also check the resident's AV shunt/fistula for thrill, and bruit. I do not take the resident's BP on the arm with AV shunt and fistula. 36734 3. Record review revealed Resident #387 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had moderate cognitive impairment, required substantial/maximum assistance with activities of daily living. The assessment further documented the resident received dialysis services. A review of Resident #387's orders did not reveal any orders for dialysis. A review of Resident #387's care plan revealed a care plan for dialysis therapy. An intervention included no blood pressures or blood draws in left upper arm. Further record review revealed Resident #387's blood pressure was documented as frequently taken in the resident's left arm. An interview was conducted with the Unit Manager (UM) on 02/27/25 at 12:00 PM. The UM acknowledged the above.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on observations, interviews and record reviews, the facility failed to follow the professional standards for controlled substances reconciliation for 2 of 5 sampled residents (Resident #443 and Resident #107). The findings included: A review of a facility policy titled, Drug Reconciliation Review-Admission/Readmission, with a revision date of 12/2022, revealed the intent of the policy is to reconcile the medications by comparing a medication history with physician medication orders, and resolving any discrepancies to prevent prescribing errors, or omissions, wrong dosage or frequency of medication, and duplicate orders of the same classification of medications. 1)A review of record revealed Resident #443 was admitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Acute Kidney Failure, Essential Primary Hypertension and Insomnia. A review of the Minimum Data Set (MDS) assessment Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating good mental cognition. A record review of a physician order dated 2/12/25 at revealed an order for Temazepam 30 milligram (MG), give 1 capsule by mouth every 24 hours as needed for insomnia. A further review of the physician orders revealed a different physician's order on 2/12/25 for Temazepam 15 MG , give 1 capsule by mouth every 24 hours as needed for Insomnia. A review of Medication Administration Record (MAR) revealed a transcribed order for Temazepam 30 MG give 1 capsule by mouth every 24 hours as needed for insomnia, with a start date of 2/12/25 at 3:30 PM and a discontinued date of 2/12/25 at 8:34 PM. There was no documented administration of this medication onto Resident #443's MAR. A further review of Resident #443's MAR, revealed Temazepam 15 MG capsule, give 1 capsule by mouth every 24 hours as needed for insomnia, with a start date of 2/12/25 and a discontinued date of 2/24/25. An additional review of the MAR for Temazepam 15 MG capsule revealed Nurses initials on the following dates and times: on 2/12/25 at 8:30 PM by Staff N, Licensed Practical Nurse (LPN); on 2/16/25 at 8:00 PM by Staff O, LPN; on 2/17/25 at 11:17 PM by Staff H, LPN; on 2/22/25 at 0:22AM by Staff P, LPN, and at 11:09 PM by Staff R, RN; and on 2/23/25 at 8:15 PM by Staff Q, LPN. There were similarities between the MAR documentation for Temazepam 15 MG with the administration of Temazepam 30 MG on the medication count sheet related to the dates and times. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a Medication Reconcilation observation with Staff A, Registered Nurse (RN), on 02/27/25 at 8:58 AM, she confirmed a Temazepam 30 MG medication dispenser card was received on 2/13/25, with 10 capsules, and Temazepam 30 MG was given as ordered, 1 capsule by mouth at bedtime for insomnia, on 2/13/25 at 8:21 PM (no Nurse signature); on 2/15/25 at 8:00 PM; on 2/16/25 at 8:00 PM; on 2/17/25 at 11:00 PM; on 2/18/25 at 9:21 PM; on 2/21/25 at 0:22 AM; on 2/22/25 at 11:01 PM; on 2/23/25 at 10:00 PM; and on 2/25/25 at 11:00 PM, with one remaining capsule in the card. An additional review of the medication dispenser card, the medication control sheet, and the MAR, revealed the nurses were administering the discontinued Temazepam 30 MG capsules, taking them from the Temazepam 30 MG medication dispenser card, putting their signatures onto the Temazepam 30 MG medication control sheet, but were documenting the medication administration in the Temazepam 15 MG box in the MAR. 2) A record review revealed Resident #107 was admitted on [DATE] with diagnoses including Displaced Intertrochanteric Fracture of Left Femur, Essential Primary Hypertension, and Anxiety. A review of MDS assessment Section C revealed Resident #107 had a BIMS score of 6 indicating impaired cognition. A review of orders dated 02/01/25 revealed Tramadol 50 MG give 1 tablet by mouth every 6 hours as needed for pain for 30 days. A record review of the MAR revealed the Tramadol 50 MG order was initiated on 02/01/25 at 2:00 PM. It revealed Tramadol 50 MG tablet was administered on 02/03/25 at 11:19 AM by Staff A, RN. During the Medication Reconcilation observation with Staff A, she verified Tramadol was received from the pharmacy on 2/2/25 with 30 capsules in the medication dispenser card. She verified the medication count sheet showed the nurse documented she administered a Tramadol on 1/3/25 at 11:10 AM. When asked how the nurse was able to give Tramadol on 1/3/25 when the medication dispenser card of 30 tablets was not received until 2/2/25, she acknowledged the date was an error, it should be 2/3/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on observation, interview, and record review, the facility failed to follow Enhanced Barrier Precautions (EBP) for 4 of 8 residents reviewed for EBP, as evidenced by not utilizing personal protective equipment (PPE) while performing physical therapy evaluation for Resident #41 and while providing assistance with feeding for Resident #388, failed to develop a care plan for EBP for a resident on Dialysis (Resident #477), and failed to implement EBP for a resident with an indwelling urinary catheter (Resident #58); and the facility failed to provide laundry services in a sanitary manner. The findings included: 1. Record review revealed Resident #41 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had mild cognitive impairment and required partial/moderate assistance with activities of daily living. A review of Resident #41's care plans revealed a care plan for an indwelling urinary catheter. An intervention included Enhanced Barrier Precautions (EBP). A review of Resident #41's orders revealed an order dated 01/17/25 for EBP for urinary catheter. Use isolation gown when in close contact with resident. An observation of Resident #41 was conducted on 02/26/25 at 9:15 AM. The resident's room door was closed. A sign was visible on the resident's door for EBP. Upon entering Resident #41's room, a staff member was observed in close proximity of the resident, taking the resident's blood pressure. The staff member addressed herself as Staff X, a physical therapist. Staff X stated she was conducting an evaluation on Resident #41 for physical therapy. Staff X did not have on an isolation gown. Staff X acknowledged she should have on an isolation gown. 2. Record review revealed Resident #388 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had severe cognitive impairment and was dependent for activities of daily living. The assessment further documented the resident had a feeding tube. A review of Resident #388's orders revealed an order dated 09/24/24 for Enhanced Barrier Precautions for enteral tube (feeding tube) and wound. Use isolation gown when in close contact with resident. A review of Resident #388's care plan did not reveal a care plan for EBP. An observation of Resident #388 was conducted on 02/24/25 at 12:15 PM during lunchtime in his room. Resident #388 was observed sitting up in a wheelchair next to his bed. A bedside table was noted between the resident and the resident's bed with a lunch tray on top. Staff Z, a Certified Nurse Assistant (CNA), was observed standing and leaning over the front of the resident, in direct contact, feeding the resident. Staff Z did not have on an isolation gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A record review revealed Resident #447 was admitted on [DATE] with diagnoses that included Mechanical Complication of Intraperitoneal Dialysis Catheter, Local Infection of the Skin and Subcutaneous Tissue, Elevated [NAME] Blood Cell Count, Encounter for Surgical aftercare following Surgery of the Digestive System and End Stage Renal Disease. A review of Minimum Data Set (MDS) Section C dated 02/24/25, revealed a Brief Interview for Mental Status (BIMS) score of 3 indicating impaired mental cognition. A review of surgical report dated 02/09/25 revealed a placement of right internal jugular tunneled hemodialysis catheter on 02/07/25. An additional record review revealed Resident #447 had a history of Multiple Resistant Staphylococcus Aureus infection at the previous peritoneal dialysis catheter site dated 02/07/25. An additional record review of physician orders dated 02/23/25 revealed an order for EBP. A further review of the resident care plans initiated on 2/22/25 did not include a focus, goals and interventions for dialysis and EBP. In an interview with Staff A, RN on 02/27/25 at 8:28 AM, when asked regarding the care of a resident on dialysis, she stated she knows a resident is on dialysis by checking the order. She makes sure the dialysis care plan is initiated, with the supporing physician orders that are immediately documented by Nurse Managers within 1- 2 days after the resident's admission to the facility. 4. Record review revealed Resident #58 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had mild cognitive impairment and required substantial/maximum assistance with activities of daily living. The assessment further documented the resident had an indwelling catheter. A review of Resident #58's care plans revealed a care plan for resistive to care at times (dated 12/23/24 as resolved). Has an indwelling catheter but refuses to use the collection bag. He is clamping the tube and goes to the toilet to empty his bladder. Further review of Resident #58's record did not reveal any documentation of the resident on EBP. There was no signage on the resident's door. 39142 5. On 02/27/25 at 8:33 AM, a laundry room and utility room tour were conducted with the Director of Nursing (DON) present. The Assistant Housekeeping and Laundry Manager ([NAME]) was present for the laundry room portion. In the dirty laundry room, there were two large, lidded, bins placed in front of the three washing machines. The [NAME] explained that dirty linens and resident clothing are brought to the laundry room in those bins or similar ones from the dirty utility rooms. The [NAME] stated she sorts the laundry from the bins into the washing machines. An observation of the bins in the laundry had discarded debris at the bottom of the bins. Contaminated linen carts raise the potential for cross contamination either through the air or by direct contact. Laundry carts and containers should be cleaned when visibly soiled per CMS. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105067	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulevard Rehabilitation Center	2839 S Seacrest Blvd Boynton Beach, FL 33435

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In the clean laundry room, above the folding tables, there was a window air conditioner unit with condensation along the bottom. There was potential for the water to drip onto the folding table and clean laundry. The water itself could be contaminated with bacteria that can become airborne or be transferred by contact with surfaces. In the dirty utility rooms on the East and [NAME] Wings there were unbagged laundry items observed in the dirty laundry bins among the bagged dirty laundry. On 02/27/25 at 9:15 AM, an observation was made of the South Wing's soiled utility room. The upright laundry cart had a vinyl like cover, which was torn and breaking apart. This could lead to small particles in the laundry cart, and hallways that can contaminate the residents' clean living spaces. 02/27/25 at 9:23 AM an Interview was conducted with the Assistant Housekeeping and Laundry Manager ([NAME]). The [NAME] stated that she has been told the CNAs bag the residents' personal laundry separately from linens. The [NAME] stated the soiled linen is also supposed to be bagged and put into the carts or bins in the soiled utility rooms. The [NAME] stated that the bins in the soiled utility rooms do travel through the halls to the laundry room. On 02/27/25 at 10:18 AM, an interview was conducted with Staff J, a Certified Nursing Assistant (CNA). Staff J stated she puts dirty linen in a bag and puts it into the linen bin in the soiled utility room. She stated she always puts the laundry in a bag and ties it up. She stated the same is done with resident's clothing. Staff J stated she was trained to handle laundry in that manner and would never handle laundry without a bag. Photographic evidence acquired. 50370