STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105219	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boca Raton Rehabilitation Center	755 Meadows Road Boca Raton, FL 33486

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to provide maintenance services necessary to maintain a sanitary, safe, clean, and homelike environment for residents. The findings included: During entrance to the facility on [DATE] at 9:10 AM, it was observed that the back area visible to residents who smoke, had old furniture, metal filing cabinets, tarp covered boxes of paraphernalia, and some uncovered boxes of gadgets. During another observation on 12/03/25 at 9: 21 AM, the same collections of furniture, boxes and gadgets were present. In an interview with the Maintenance Director, he stated he is trying to organize all these gadgets, furniture and supplies that came from a storage box. When he was asked when he would think it would be organized, he did not respond. In an interview conducted with a resident, she stated that the view is not good for relaxation because it seemed like trash is everywhere. An additional tour of one of the resident's rooms revealed that the bathroom had no trash bin, with 1 (one) defective light above the bathroom sink, 2 defective lights, and a missing mirror above the sink inside the main room. There was a rusted uncovered screw at bottom part of the toilet seat. The other rooms in that section all have trash bins in the bathrooms, working lights above the bathroom sink, and the main room with mirrors above the main room sink. A tour of the room on the opposite side revealed defective bathroom sink lights and above the sink lights in the main room. In an interview conducted with the Maintenance Director on 12/02/25 at 3:30 PM, he stated he started working 3 weeks ago and he is still trying to get inventories of all necessary repairs inside the facility. In interviews conducted with the nurses and Certified Nursing Assistants (CNA) on that section of the facility on 12/02/25 at 11:30 AM, they stated that they tried to work with minimum lights and use the other trash bins inside the residents' rooms if there are no trash bins in the residents' bathrooms. They added they learned to live with these lacks. They added that they noticed the holes inside the residents' rooms too, but stated the management is aware. During a continuing tour of the facility on 12/02/25 at 3:45 PM, and 12/03/25 at 10:30 AM, it was observed that some areas have holes like in the bathroom doors, and behind the residents' beds. When the residents were asked, they stated that they told staff about the holes, and they never received responses on when they will be fixed. In interviews conducted with other residents on 12/02/25 at 11:30 AM, they stated that the main dining room ceiling had been leaking for months, staff were aware, but nothing had been done. They added that there is also a ceiling leak in the short hall area that staff had been aware, but still nothing had been done. They wanted to know when these areas would be repaired. In interviews conducted with the NHA and the DON on 12/02/25 at 4:05 PM, when they were asked about the leaks in the main dining room and the short hall, they responded that no residents have been using the main dining room in 10 months. They provided no reason for the Main Dining Room to be closed. In an interview with the DON on 12/02/25 at 11:45 AM, she was asked to provide the work order for the leaks in both the short hall and the main dining room, she responded that she would ask the Maintenance Director. Nothing had been submitted to the Surveyor.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to follow the professional standards of practice for ensuring medications and treatments were administered according to doctor's orders for 2 of 2 sampled residents (Residents #4 and #6). The findings included: During an entrance conference with the Director of Nursing (DON), and Staff A, Licensed Practical Nurse, on 12/02/25 at 9:30 AM, they were asked to provide the medication administration policy.1) Resident #4 was admitted to the facility on [DATE] with diagnoses that included Muscle Wasting and Atrophy, Essential Primary Hypertension, and Unspecified Disorders of the Muscle.A review of recent Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #4 had good cognitive function. A review of physician order dated 07/14/24 documented Lyrica, 150 milligrams (mg), give one tablet every 6 hours for nerve pain. A review of the Medication Administration Record (MAR) for November 2025 documented on 11/30/25 that Lyrica was administered at 6:00 PM and at 7:00 PM by 2 different Nurses based on initials in the Controlled Drug Declining Inventory Sheet and according to interviews with Staff A, Licensed Practical Nurse (LPN), and Staff C, Registered Nurse (RN). During an interview conducted with Staff A, LPN, on 12/03/25 at 11:20 AM, she stated that the Nurse administered the medication at 6:00 PM on 11/30/25, and another Nurse administered the above medication at 7:00 PM indicating the physician order was not followed. During an interview conducted with Staff C, RN on 12/03/25 at 1:00 PM, she stated that based on the Medication Administration Record (MAR) for Resident #4, it documented that the medication was administered to him at 6:00 PM on 11/30/25 by a Nurse with different initials from the Nurse who administered the same medication on 11/30/25 at 7:00 PM. She added that the physician order was not followed. 2) Resident # 6 was admitted to the facility on [DATE] with diagnoses that included Respiratory Failure, Malignant Neoplasm of Supra glottis, Dysphagia, Oropharyngeal Phase, and Tracheostomy Status. A review of Medication Administration Record (MAR) sent electronically by the DON on 12/05/25 documented Resident #6 had orders for tracheostomy care daily as follows: Cleanse site with normal saline, pat dry and cover with drain sponge daily and as needed. Additional review of MAR documented that from 12/01/25 until 12/03/25, the order was not followed due to absence of check marks and nurse's initials parallel to the order. In an interview conducted with Staff C, RN on 12/03/25 at 1:08 PM, when she was asked if they stored solutions, and biologicals at resident's bedside, she responded, no. When she was asked if a tracheostomy care physician order must be followed by staff she responded yes. When she was asked how would staff know that a tracheostomy care order was followed and done by staff, she responded that parallel to the order are Nurse's initials and check marks.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and interviews, the facility failed to follow State Law and the professional standards of practice for Intravenous (IV) therapy, for 1 of 4 sampled residents (Resident #1). The findings included: In the State of Florida, for an LPN to administer IV Therapy, they must meet the requirements of the Florida Board of Nursing (FBON) and Rule 64B9-12 Florida Administration Code (Administration of Intravenous Therapy by Licensed Practical Nurses). The required course to become IV Certified is no less than 30-hours, and administered by a FBON approved provider. Resident #1 was admitted to the facility on [DATE] with diagnoses that included Infection and Inflammatory Reaction due to Internal Right Knee Prosthesis, subsequent encounter; Muscle Wasting and Atrophy; Methicillin Resistant Staphylococcus Aureus (MRSA) Infection of the Unspecified Site; and Encounter for Other Orthopedic Care. A review of Minimum Data Set (MDS) assessment dated [DATE], under Section C of the Brief Interview of Mental Status (BIMS) revealed a score of 15 indicating Resident #1 had no cognitive impairment. A review of orders dated 07/19/25 revealed Daptomycin intravenous solution, use 650 milligram (mg) IV for infection, one time a day for wound until 08/27/25. During an entrance conference on 12/02/25 at 9:30 AM with the Director of Nursing (DON) and Staff A, Licensed Practical Nurse (LPN), they were asked to provide certification, education and training for IV therapy of all LPNs working in the facility. They were also asked for the sign-in sheet of all staff who attended training and in services for infection control, and the medication administration policy. The DON responded, we will provide them. A review of Resident #1's August 2025 Medication Administration Record (MAR) revealed that Daptomycin 650 mg IV was administered by Licensed Practical Nurses (LPNs) based on the initials documented in Medication Administration Record (MAR). The LPNs' initials were confirmed by DON and Staff A, LPN on 12/2/25 at 1:00 PM. When the DON was asked if this surveyor can interview any of the LPN staff on the list, she responded they are not working today. When she was asked if this surveyor may interview them over the telephone, she responded, sure, we will find their numbers and will give them to you. No telephone numbers were provided for this surveyor. During an interview conducted on 12/02/25 at 11:30 AM with Staff B, Registered Nurse (RN), when she was asked if the LPNs in the facility administer IV medications for residents, she responded, yes. When she was asked if she accompanied the LPNS during IV administration, she responded, they go by themselves because they give IV therapy to their assigned residents, and I have my own assigned residents. On 12/02/25 at 12:50 PM the DON was asked again for the certification, education and training of all LPNs, and the sign in sheet of training and in-services for all staff, she responded that she is still gathering the paperwork. She was reminded to provide the other requested paperwork during the entrance conference. She was informed that the electronic access to this surveyor had stopped. An interview was conducted on 12/02/25 at 1:30 PM with DON and Staff A, LPN, who confirmed that the initials on the MAR for Resident #1 belong to some LPNs. They were both asked for the education, training and certification of all LPNs on the list and they told this surveyor that they will bring them later. On 12/02/25 at 3:00 PM, two RNs were asked if one of them can direct this surveyor to a resident with an IV therapy, they both responded, the resident was asleep, but the next shift Nurse might accompany the surveyor. When this surveyor approached the next shift nurse, Staff A, LPN, stated that the LPN was preparing for the change of shift, but she will call the surveyor when she is done. Staff A, LPN was asked by this Surveyor to print the MAR of the resident who is receiving IV therapy and she responded, sure. She was reminded that this surveyor has no access to residents' record. She was again asked for electronic access. On 12/02/25 at 5:00 PM, the DON was asked again for the education, training and certification of all the LPNs in the facility, she responded, I am still gathering the documents. She was reminded about the infection control training sign in sheet for all staff, and electronic access for residents' record. On 12/02/25 at 5:30 PM, when the DON was asked for the certification, education and training for IV therapy of all LPNs in the facility, she responded that only Registered Nurses give IV therapy, so there are no certifications required for all the LPNs. She was asked to provide the medication policy of the facility and the sign-in sheet for all the recent infection control training provided for all staff, she responded, yes, we will provide them. She was also asked for electronic access to residents' record. On 12/02/25 at 5:45 PM, Staff A, LPN, was asked for the IV therapy observation with an LPN, she responded, the resident does not get the IV therapy until 8 PM, and the staff are helping residents for dinner. She was asked to provide this surveyor with the MAR of the resident with IV therapy. She was also asked additional information like the name of the resident, and the