

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105476	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Legacy at Boca Raton Rehabilitation and Nursing Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 6363 Verde Trail Boca Raton, FL 33433	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057</p> <p>Based on observations, interviews and record review, the facility failed to provide a clean environment free of offensive odor in 1 of 3 units (Berkshire Unit). As evidenced by a foul urine like odor, noted during a tour of the facility.</p> <p>The findings included:</p> <p>On 07/02/24 at 9:32 AM, a tour to the facility's Berkshire Unit started. Observation revealed a strong offensive, urine like odor, down the hallway between room [ROOM NUMBER] and 210.</p> <p>On 07/02/24 at 10:18 AM, observation revealed Staff A, Housekeeper mopping room [ROOM NUMBER]'s floor and bathroom. Observation revealed the foul urine like odor continued outside the room.</p> <p>On 07/02/24 at 10:24 AM, observation revealed a foul urine like odor inside room [ROOM NUMBER].</p> <p>On 07/02/24 at 10:35 AM, the Surveyor attempted to interview Staff A, but she did not understand the questions asked. Staff A was asked to call her manager.</p> <p>On 07/02/24 at 10:39 AM, an interview was conducted with the Berkshire Unit Manager who stated that the housekeeper saw urine and noted urine odor in room [ROOM NUMBER].</p> <p>On 07/02/24 at 10:40 AM, a joint interview was conducted with Staff A, Housekeeper and the Housekeeping Director (HD) who translated for Staff A. The HD translated that Staff A saw urine in room [ROOM NUMBER]'s bathroom and cleaned it.</p> <p>On 07/02/24 at 10:50 AM, a side by side observation of room [ROOM NUMBER]'s bathroom was conducted with the HD who confirmed the strong urine like odor in the bathroom.</p> <p>On 07/02/24 at 11:00 AM, it was noted that the urine like odor continued in the Berkshire Unit hallway between rooms 209, 210, 219 and 220.</p> <p>(continued on next page)</p>

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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/02/24 at 11:03 AM, observation revealed the District Housekeeping Manager picking up a urine drainage bag connected to a catheter from the floor underneath an empty bed in room [ROOM NUMBER], by the window. Further observation revealed the bag had small amount of dark (blood like) colored fluid. Consequently, an interview was conducted with the District Housekeeping Manager who confirmed a strong urine like odor in the room and stated they will do a thorough cleaning to the room.</p> <p>On 07/02/24 at 11:05 AM, an interview was conducted with Staff B, Licensed Practical Nurse (LPN) who stated he did not notice a urine odor in room [ROOM NUMBER].</p> <p>On 07/02/24 at 11:33 AM, an interview was conducted with Staff C, LPN who stated that she smelled a urine like odor between rooms [ROOM NUMBERS] and added the odor was right on that section.</p> <p>On 07/02/24 at 12:39 PM, observation revealed a strong urine like odor continued in the Berkshire Unit between rooms 209, 210, 219 and 220.</p> <p>On 07/02/24 at 5:09 PM, observation revealed a mild urine like odor continued between room [ROOM NUMBER] and 210 at the Berkshire Unit.</p> <p>On 07/02/24 at 6:15 PM, during an interview, the Administrator stated he was aware of the urine like odor in the Berkshire Unit and added that a thorough cleaning was done. He was apprised that at 5:00 PM, a mild odor remained in the hallway.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057</p> <p>Based on record review, observations and interviews, the facility failed to identify and treat resident's skin redness/rash for 1 of 3 sampled residents (Resident #3). As evidenced by a redness area observed on Resident #3's chest, right upper arm and left upper arm, with no documented treatment in place.</p> <p>The findings included:</p> <p>Review of Resident #3's clinical record documented an admission to the facility on [DATE] with no readmissions. The resident's diagnoses included Ataxia (poor muscle control that causes clumsy movements), Dementia without Behavioral Disturbance, Anxiety Disorder, Chronic Kidney Disease and Left and Right Foot Pain.</p> <p>Review of Resident #3's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident had no cognition impairment. The assessment documented under Functional Abilities and Goals that the resident needed supervision or touching assistance from the staff to complete the activities of daily living including personal hygiene and upper body dressing.</p> <p>On 07/02/24 at 9:47 AM, an interview was conducted with Staff F, Certified Nursing Assistant (CNA) who stated if she sees a skin rash or any issues with the resident's skin, she will tell the nurse. Staff F was asked if the nurse response to her on the same day and stated Yes.</p> <p>On 07/02/24 at 11:45 AM, observation revealed Resident #3 in bed in an upright position wearing a blue blouse. An interview was conducted with the resident who stated she wore a hospital gown for 2-3 days at least. The resident was asked the reason for her to wear the same gown for 2-3 days and stated she was told that they did not have any more gowns. The resident stated today (07/02/24), this morning, during a casual conversation with the CNA, she asked her to put on her own gown and pointed to the blue blouse she was wearing. During the interview, Resident #3 was asked if she had any skin rash or any skin breakdown, the resident immediately pulled her left arm sleeve up and pointed to a skin rash on her left upper arm, pulled the right arm sleeve up and pointed to the back of her arm. Observation revealed the resident had redness to her right upper arm and on the back of her left upper arm.</p> <p>Furthermore, observation revealed the resident had redness to her upper chest, visible without having to remove her blouse. The resident stated it may be because of wearing the same hospital gown for 2-3 days. Further observation revealed the resident had a Midline inserted on her right arm and redness was noted in the back of her arm. The resident started to scratch herself during the observation and stated it is itching now. Resident #3 was asked if the nurse was aware of the rash and stated she told the (girls) CNAs and did not know if the nurse was aware of her skin redness/rash. The resident added the rash is all the way up to my shoulder. The resident was asked if she was taking anything for the rash and stated No.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/02/24 at 12:13 PM, a side by side observation of Resident #3's skin redness to her upper arms and chest was conducted with Staff B, Licensed Practical Nurse (LPN). Staff B stated the resident had a cream for her skin rash. During the observation, Resident #3 stated she had not had any cream put on the rash.</p> <p>Review of Resident #3's active care plan lacked any written evidence of an updated skin care plan related to the resident's skin redness/rash.</p> <p>Review of Resident #3's June and July 2024 Medication and Treatment Administration Record lack written documentation related to the resident's skin redness/rash.</p> <p>Review of Resident #3's clinical record lack a written physician order for the resident's skin redness/rash.</p> <p>Review of Resident #3's clinical record nursing progress notes and skin assessments lack written evidence related to the resident's skin redness/rash.</p> <p>On 07/02/24 at 12:15 PM, a side by side review with Staff B and the Unit Manager of Resident #3's clinical record was conducted. The Unit Manager stated there was not a physician order for the resident's skin rash.</p> <p>On 07/02/24 at 12:18 PM, a side by side observation of Resident #3's skin rash/redness was conducted with the Unit Manager. The unit manager looked at the resident's upper arm and chest redness and stated she will call the physician for an order. During an interview, the unit manager stated the resident was out of bed on 07/01/24, had her own clothes on and went to therapy and added the resident had confusion at times.</p> <p>On 07/02/24 at 12:38 PM, an interview was conducted with Staff F, CNA assigned to the Resident #3 who stated she provided care to the resident this morning and the resident asked to put her own clothes on (blue blouse). The CNA stated she saw the resident's skin rash/redness and the nurse was aware of it.</p> <p>On 07/02/24 at 5:10 PM, an interview was conducted with Staff E, LPN who stated she worked on 06/30/24 and saw Resident #3's Midline catheter on her right arm but did not notice any skin redness/rash.</p> <p>On 07/02/24 at 6:10 PM, during an interview the Director of Nursing was apprised of the findings.</p>		