

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 04/10/2024
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 - Some</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** 01948</p> <p>Based on observation and interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior on the B Wing (1 of 33 rooms), C Wing (17 of 33 rooms) and D Wing (1 of 39 rooms).</p> <p>The findings included:</p> <p>During the initial resident/room screenings conducted on 04/07/24 from 9 AM-3 PM, and the Environment Tour conducted on 04/10/24 at 10 AM, accompanied with the facility's Assistant Administrator and Corporate Housekeeping Manager, the following were noted:</p> <p>B Wing:</p> <p>room [ROOM NUMBER] - Electric bed (A Bed) not working, staff not able position resident for assistance with feeding the lunch meal.</p> <p>C Wing:</p> <p>room [ROOM NUMBER]: Nurse call bell cord was wrapped around the bed frame (W Bed) and the resident was not able to reach the call button; bathroom ceiling tiles (2) noted to have large black mold areas (5 X 7); and the filter of the O-2 concentrator was dust laden.</p> <p>room [ROOM NUMBER] - Portable toilet commode seat exterior was rusted.</p> <p>room [ROOM NUMBER]: The exterior bed frame (W Bed) was heavily rusted; bathroom wall (1) was in disrepair; and the room walls (2) were in disrepair.</p> <p>Room # 312: The room windows (2) were covered in a green algae matter.</p> <p>Room# 314: Bar soap (2) was observed on top of the paper towel dispenser, and a cup of white ointment with a spoon was observed on top of the paper towel dispenser.</p> <p>room [ROOM NUMBER]: The bed rail (D-Bed) was noted to become unattached from the bed rail and was on the room floor.</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 - Some</p>	<p>Hallway/Resident Room Entry:</p> <p>The room threshold entry floor cover strip was missing resulting in a potential fall hazard that included rooms: #302, #306, #323, #332, #324, #325, #328, #312, #314, #317 and #320.</p> <p>D Wing:</p> <p>room [ROOM NUMBER]: Nurse call light was wrapped around the bed frame and the resident stated she was unable to reach the call button.</p> <p>Following the 04/10/24 tour the findings were again discussed and confirmed with the Assistant Administrator and Corporate Housekeeping Manager. The findings were again discussed with the facility's administration.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893</p> <p>Based on observations, interviews and record review, the facility failed prevent verbal abuse towards a resident from a staff member for 1 of 1 sampled resident, (Resident #54).</p> <p>The findings included:</p> <p>Record review revealed the facility's policy titled, 'Identifying Types of Abuse' (no reference date documented on the policy) documented, in part:</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. Abuse of any kind against residents is strictly prohibited. 2. Abuse prevention includes recognizing and understanding the definitions and types of abuse that can occur. 3. It is understood by the leadership in this facility that preventing abuse requires staff education, training and support, and a facility-wide culture of compassion and caring. 4. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. <ol style="list-style-type: none"> c. Abuse includes verbal abuse. 5. Abuse toward a resident can occur as: <ol style="list-style-type: none"> b. staff-to-resident abuse. <p>Mental and Verbal Abuse</p> <ol style="list-style-type: none"> 2. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal, written or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. 3. Examples of mental and verbal abuse include, but are not limited to: <ol style="list-style-type: none"> c. Yelling or hovering over a resident, with the intent to intimidate. <p>Psychosocial Outcomes</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Some situations of abuse to not result in an observable physical injury or the psychosocial effects of abuse may not be immediately apparent. In addition, the alleged victim may not report abuse due to shame, fear, or retaliation. Other residents may not be able to speak due to a medical condition and/or cognitive impairment (e.g. stroke, coma, Alzheimer's disease), cannot recall what has occurred or may not express outward signs of physical harm, pain, or mental anguish. Neither physical marks on the body nor the ability to respond and/or verbalize is needed to conclude that abuse has occurred.</p> <p>2. Abuse ay result in psychological, behavioral, or psychosocial outcomes including, but not limited to the following:</p> <p>a. Fear of a person or place, of being left alone, of being in the dark, and/or disturbed sleep and nightmares.</p> <p>b. Extreme changes in behavior, including aggressive or disruptive behavior toward a specific person; and</p> <p>c. Running away, withdrawal, isolating self, feelings of guilt and shame, depression, crying, talk of suicide or attempts.</p> <p>3. The following situations are recognized as those that are likely to cause psychosocial harm which may take months or years to manifest, and have long-term effects on the resident and his/her relationship with others:</p> <p>d. Any staff to resident physical, sexual, or mental/verbal abuse.</p> <p>Further review of provided documentation revealed an in-service was conducted on 03/21/24 and 03/22/24. The in-service was based on their policy titled, 'Abuse Recognition and Response in Healthcare' (no reference documented on policy), that included, Types of Abuse: Verbal Abuse: the use of words to cause harm, such as name-calling, yelling, or excessive criticism.</p> <p>Record review revealed Resident #54 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS), dated [DATE], Resident #54 had a Brief Interview for Mental Status (BIMS) score of 14, indicating cognitively intact, with vision and hearing documented as being 'adequate'. The MDS documented that the resident ambulated independently via wheelchair. Resident #54's diagnoses at the time of the assessment included: Coronary Artery Disease, Hypertension, Peripheral Vascular Disease, Diabetes Mellitus, Depression, Atrial Fibrillation, Benign Prostatic Hyperplasia, Glaucoma (bilateral), and Presence of Cardiac Defibrillator.</p> <p>On 04/08/24 at 9:30 AM, Staff K, Certified Nursing Assistant (CNA) was pushing a trolley containing used wares from residents while having breakfast in their rooms. The Surveyor heard a crash and turned around to witness Staff K yelling at Resident #54, stating Why did you do that. You knew I was there, and you rolled in front of me. When Staff K was asked about speaking to the resident in that manner and not checking on the resident, she stated, I am just kind of short when things like that happen.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/08/24 at 9:32 AM, the Surveyor asked Resident #54 if he was hurt and if anything from the cart had hit or injured him to which Resident #54 replied that nothing hit him. When asked about Staff K yelling at him in that manner, Resident #54 stated that he did not realize that Staff K was yelling due to, I couldn't really hear her because my ears hurt and were ringing from the crash.</p> <p>During a follow up interview, on 04/09/24 at 10:16 AM with Resident #54, when asked about the incident, Resident #54 replied, I was sitting there and all of a sudden it ran into me. My ears are bothering me from the loud bang when the dishes hit the floor. I saw her but it was too late. I was just sitting there, and she ran into me. That was [.] that I moved, and I didn't. I was just sitting there, and I saw her coming at me.</p> <p>During an interview, on 04/09/24 at 10:48 AM, with Staff U, Licensed Practical Nurse (LPN), when asked about the incident, Staff U replied, I was in another room with another resident. I heard a crash and then I came out. I looked at Resident #54 and didn't know if he did anything and there were broken dishes on the floor. I took a breath and didn't know what was going on. I consoled Resident #54, and he was okay, and he said he was alright'. Staff U further stated that he did not approach Resident #54 until after the Surveyor checked on him. Staff U stated that there had not been any other incidents of staff verbally abusing residents that he was aware of.</p> <p>During an interview, on 04/09/24 at 10:53 AM, with Staff V, Registered Nurse (RN), when asked about the incident, Staff V replied, I didn't see anything, but I was there'. When asked about checking on Resident #54, Staff V replied, I was actually looking at the resident and I had some medication in my hand that I couldn't put down. I just looked to see if the resident was on the floor or not. When asked about assessing a resident based on the incident, Staff V replied, we should assess the resident to see if they are okay, assess the patient, assess the area for risk. I was looking around, but I didn't see if they had a wet sign so that nobody would slip and fall. Staff V stated that there had not been any other incidents of staff verbally abusing residents that she was aware of.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>49060</p> <p>Based on observations, interviews, and record review, the facility failed to report an injury of unknown origin in a timely manner for 1 out of 1 sampled resident reviewed for skin discoloration (Resident #104).</p> <p>The findings included:</p> <p>Review of the facility's policy/Job description titled, Job description: Certified Nursing Assistant, undated, included the following:</p> <p>Job Summary: The purpose of this position is to assist the nurses in the providing of resident care primarily in the area of the daily living routine.</p> <p>Main Duties:</p> <p>H. Report any changes in resident's condition-e.g. eating habits, behavior, temperature, etc. to the charge nurse of the unit.</p> <p>M. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty.</p> <p>P. Detect and report situations that have a high probability of causing accidents or injuries to residents and/or staff.</p> <p>During an observation on 04/10/24 at 8:40 AM of the Dining Room located at the C-Unit, the surveyor noted Resident #104 was yelling and crying out that her hands hurt. Further observation revealed her right ring finger appeared swollen and on the left side of the mouth a red purplish area with slight dry blood-like on the lips was noted. The surveyor observed the Infection Preventionist removed Resident #104 from the dining room and headed to Resident #104's room.</p> <p>At this time, an interview was conducted with the Infection Preventionist. She stated that she was taking Resident #104 back to her room to evaluate the hand. The surveyor questioned the red purplish area by Resident #104's mouth. The Infection Preventionist stated that she had not noticed the bruise. Upon investigation of Resident #104's face, she stated that it appeared to be a new bruise and would investigate.</p> <p>On 04/10/24 at 9:12 AM, another interview was conducted with the Infection Preventionist. She stated that the Certified Nursing Assistant (CNA) stated that she noticed it this morning and reported it to the unit nurse. She also stated that Resident #104 received medication for the pain, and once she is moved to her bed, they would conduct a full skin assessment.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 04/10/24 at 9:30 AM with Staff G, Licensed Practical Nurse (LPN), the nurse assigned to Resident #104. She stated that she was not aware of the bruise on Resident #104's face and did not see any documentation. She also stated that the CNA only mentioned that the resident had redness on her back. At this time, Staff G assessed Resident #104's face and stated that yes, it is a bruise and that the resident was unable to recall what happened. She then stated that she would need to write an incident report for further investigation.</p> <p>On 04/10/24 at 10:36 AM, the Infection Preventionist (IP) returned to the C-Unit and stated that risk management had contacted the police for investigation, and she notified Resident #104's spouse, who stated that the bruise might be due to her complaining of a toothache the other day, but he did not mention it to the staff. The IP stated that she had contacted social services for a Dental consultation. She also stated that Resident #104 is on an anticoagulant medication and consequently she bruises easily. In addition, she stated that she spoke with Staff H, CNA, and that Staff H reported a redness on resident's back, not the bruise on the face.</p> <p>On 04/10/24 at 10:56 AM, an interview was conducted with the Director of Nursing (DON), who was in the resident's room. She stated that she performed a full skin assessment on Resident #104 and no other bruises were noted. The DON also spoke with the Resident #104's spouse and he stated that the resident had complained about a toothache, but she believes that the toothache is on the right side of the face not the left. She also stated that she asked the Restorative CNA to stay in the room with Resident #104.</p> <p>On 04/10/24 at 11:03 AM, an interview was conducted with Staff H, the CNA assigned to Resident #104. She stated that she reported the rash on Resident #104's back but not the bruise on her face. Staff H stated that she did not think it was a bruise because she found Resident #104 sleeping with the left side of her face against the bed siderail. She stated that after she dressed the Resident #104, she moved the resident in her wheelchair to the dining room for breakfast, and she went to assist another resident.</p> <p>On 04/10/24 at 1:03 PM, an interview was conducted with Resident #104's spouse, in the resident's room. He stated that he was contacted yesterday by the staff about the swelling of the right ring finger. He mentioned that the staff was trying to remove the ring from the finger due to the swelling, but she expressed that it hurts her too much. He also stated that the staff contacted him today for the bruise on Resident #104's face and believes that it was caused by a toothache.</p> <p>Review of the Incident Note dated 04/09/24 documented that Resident #104 was observed with a slight redness and swollen area to right fourth finger and an X-ray was ordered.</p> <p>Review of the Nursing Progress Note dated 04/10/24 documented that Resident #104 was crying in the Dining/Day room on the C-Unit and was assisted back to her room for assessment. Resident #104 complained of pain in her hands. The nurse medicated the resident with Tylenol. Skin discoloration was noted to the left side of the mouth. Resident denied pain to the mouth and is unable to explain what happened. The Abuse coordinator was notified.</p> <p>The surveyor reviewed all the progress notes and found no documentation of the bruise on Resident #104's face prior to the above progress note dated 04/10/24. In addition, no staff in the Dining room noted the bruise until the surveyor pointed it out.</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** 49060</p> <p>Based on observations, interviews, and record review, the facility failed to provide and identify the need for psychosocial assessments in a timely manner for 1 out of 1 sampled resident reviewed for disruptive yelling out behaviors (Resident #104). The facility also failed to follow Physician's orders to report blood sugar readings of 400 and above to the Physician for 1 out of 1 sampled resident reviewed for insulin (Resident #323). In addition, the facility failed to perform a skin assessment in a timely manner for 1 out of 1 sampled resident reviewed for skin condition (Resident #71).</p> <p>The findings included:</p> <p>1) Record review for Resident #104 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Cerebral Infarction, Dementia, and Depression.</p> <p>Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #104 had a Brief Interview for Mental Status score of 6, which indicated that she had severe cognitive impairment. Review of Section D revealed that Resident #104 was often feeling depressed or hopeless. Review of Section GG revealed that Resident #104 was dependent on the staff for most of her Activities of Daily Living (ADLs).</p> <p>Review of the Physician's Orders showed that Resident #104 had the following orders: Memantine HCl 5 mg tablet dated 10/13/23 for Dementia; Lexapro 10 mg tablet dated 10/31/23 for Depression; Valproic Acid (Depakote) Solution 10 ml dated 04/04/24 for Mood Disorder; Lorazepam (Ativan) Injection 0.25 ml every 8 hours as needed (PRN) for 10 Days dated 04/04/24 for Anxiety; Psychiatry consult for medication management and increased behaviors dated 03/19/24.</p> <p>Review of the Care Plan dated 01/16/24 documented that Resident #104 had potential to be disruptive, yelling out due to Dementia and ineffective coping skills. The goals were to decrease episodes of disruptive yelling out. Interventions included: assessing and anticipate resident's needs (food, thirst, toileting needs, comfort level, body positioning, pain, etc.); When the resident becomes agitated: Intervene before agitation escalates.</p> <p>Review of the Nursing Progress notes dated from 03/19/24 to 04/10/24 documented that Resident #104 refused care at times, yelling, and crying; the staff tried to talk to the resident, and she continues to scream, kick, and even tries to punch the staff.</p> <p>During the initial tour of the facility conducted on 04/07/24 at 12:38 PM, the surveyor noted a disruptive yelling coming from the C-Unit hallway. A visitor passed by and stated that the yelling is constant and disruptive to the other residents. Upon further investigation, the disruptive yelling was noted to be coming from Resident #104's room and no staff member was noted in the room.</p> <p>On 04/07/24 at 12:41 PM, an interview was conducted with Resident #104's roommate. She stated that Resident #104 screams all the time and fights with staff while they provide care. She also stated that Resident #104 even yells when she is in the dining room at mealtimes and the staff does nothing to help her.</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 04/08/24 at 2:30 PM, an interview was conducted with the Director of Social Services. She stated that she was aware of Resident #104's disruptive yelling behaviors. She also stated that the staff tried to get Resident #104 to do other activities, distract her or try to reason with her, but it has not worked. She also stated that Resident #104's roommate filed a grievance due to the yelling and offered the roommate a change of room (no mentioned of assessing Resident #104's disruptive yelling out behaviors).</p> <p>An interview was conducted on 04/09/24 at 8:59 AM with Staff E, Licensed Practical Nurse (LPN). She stated that when Resident #104 first came to the facility, she was combative during care, but not yelling, however, lately Resident #104 has gotten worse. She also stated Resident #104 would benefit from getting anxiety medication on a routine basis.</p> <p>On 04/09/24 at 9:06 AM, an interview was conducted with Staff F, Certified Nursing Assistant (CNA). She stated that Resident #104 is very agitated and combative when she provides care, and usually, Resident #104 requires two to three CNAs to provide the care. She also stated that a resident complaint to her about the screaming and crying across the hallway.</p> <p>On 04/09/24 at 12:47 PM, an interview was conducted with a resident across Resident #104's room. She stated that she realizes that no facility is perfect, however, she does not like the constant disruptive yelling and crying.</p> <p>Review of the psychiatric progress note dated 02/15/24 documented that Resident #104 requires frequent follow up to ensure safe and effective psychotropic medication management. In addition, Resident #104 would be monitored for changes in mood or behaviors.</p> <p>Review of the psychiatric progress note dated 04/10/24 documented that Resident #104 had been refusing her Lexapro and Depakote medications which is probably why she (Resident #104) is so restless and agitated at times.</p> <p>Review of the April Medication Administration Record (MAR) documented that Resident #104 has not refused Depakote since the Physician's order dated 04/04/24. Further investigation of the MAR for March and April documented that Resident #104 had not refused Lexapro since 03/07/24. In addition, since the Physician's order for Lorazepam (Ativan) injections (PRN) for anxiety dated 04/04/24, the MAR documented that Resident #104 received 6 doses, last dose administered on 04/10/24 (6 doses in 7 days).</p> <p>38893</p> <p>2). The facility's policy titled, 'Nursing Manual: Obtaining a Fingerstick Glucose Level', revised 11/08/21, documented:</p> <p>Documentation:</p> <p>*The person performing the blood glucose test by fingerstick should record the following information in the resident's medical record:</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>6. the blood sugar results. Follow facility policies and procedures for appropriate nursing interventions regarding blood sugar results (if resident is on a sliding scale coverage, and/or physician interventions is needed to adjust insulin or oral medication dosages), etc.</p> <p>Reporting:</p> <ol style="list-style-type: none"> 1. Report results promptly to the supervisor and the Attending Physician. 2. Notify the supervisor if the resident refuses the procedure. 3. Report other information in accordance with facility policy and professional standards of practice. <p>Resident #323 was admitted to the facility on [DATE]. According to the residents most recent full assessment, an Admission Minimum Data Set (MDS), dated [DATE], Resident #323 had a Brief Interview for Mental Status score of 14, indicating that Resident #323 was 'cognitively intact. Resident #323's diagnoses at the time of admission included: Type 2 Diabetes Mellitus, Benign Prostatic Hyperplasia, Obstructive Sleep Apnea, Orthostatic Hypotension, Hyperlipidemia.</p> <p>Resident #323's Orders included:</p> <p>Insulin Lispro (1 Unit Dial) 100 UNIT/ML Solution pen-injector - INJECT SUBCUTANEOUSLY PER SLIDING SCALE: THREE TIMES PER DAY : IF 151 - 200 = 1 UNIT BELOW 75 CALL MD; 201 - 250 = 2 UNIT; 251 - 300 = 3 UNIT; 301 - 350 = 4 UNIT; 351 - 400 = 5 UNIT; 401 - 450 = 6 UNIT ABOVE 400 CALL MD, FOR DIABETES;INJECT 8 UNITS SUBCUTANEOUSLY BEFORE MEALS AND AT BEDTIME FOR DIABETES - 03/24/24.</p> <p>Resident #323's care plan for diabetes mellitus, initiated 03/25/24, documented, Resident is at risk for complications related to Diabetes Mellitus.</p> <p>The goal of the care plan was documented as, the resident will have no complications related to diabetes through the review date with a target date of 04/12/24.</p> <p>Interventions to the care plan included:</p> <ul style="list-style-type: none"> o Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Date Initiated: 03/25/2024 . o Monitor/document/report to Medical Doctor (MD) PRN (as needed) s/sx (signs /symptoms) of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait. Date Initiated: 03/25/2024. o Monitor/document/report to MD PRN for s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, coma. Date Initiated: 03/25/2024. <p>During an interview, on 04/08/24 at approximately 11:00 AM, Resident #323 stated, I have never had blood sugars over 200 before I got here. Since I have been here, I have had 300, 400 and up to 600. I don't know what they are doing here.</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>A review of Resident #323's Medication Administration Record (MAR) for March 2024 and April 2024 in the resident's electronic health record revealed the following.</p> <p>On 03/24/24, Resident #323's blood glucose reading prior to dinner was 496.</p> <p>On 03/24/24, Resident #323's blood glucose reading at bedtime was 425.</p> <p>On 03/27/24, Resident #323's blood glucose reading prior to dinner was 533.</p> <p>On 04/02/24, Resident #323's blood glucose reading prior to dinner was 439.</p> <p>On 04/04/24, Resident #323's blood glucose reading prior to breakfast was 411.</p> <p>On 04/04/24, Resident #323's blood glucose reading prior to dinner was 450.</p> <p>On 04/06/24, Resident #323's blood glucose reading prior to dinner was 421.</p> <p>On 04/07/24, Resident #323's blood glucose reading prior to dinner was 449.</p> <p>A review of the resident's progress notes during that time frame lacked any documentation of the MD being notified of the blood glucose readings to determine interventions that may have been needed.</p> <p>During an interview, on 04/09/24 at 4:01 PM, with Staff W, Licensed Practical Nurse (LPN), the LPN confirmed the documentation and timing of the blood glucose reading in Resident #323's MAR. When asked about notifying the MD of the resident's blood glucose readings being over 400, Staff W replied, I take his blood sugar and write it down and document later. Sometimes I forget.</p> <p>36057</p> <p>3) Review of Resident #71's clinical record documented an admission to the facility on [DATE] with no readmissions. The resident's diagnoses included, in part Sepsis, Urinary Tract Infection (UTI), Unspecified Dementia, Depression and Generalized Anxiety Disorder.</p> <p>Review of Resident #71's physician orders dated 03/11/24 documented Moisture barrier cream to sacral/buttocks every shift as needed every day.</p> <p>Review of Resident #71's Weekly Skin Observation dated 04/08/24 documented no new open areas noted.</p> <p>Review of Resident #71's care plan titled, [Resident name] requires assistance with Activities of Daily Living (ADL) due to functional decline related to Sepsis, UTI and Dementia initiated on 03/11/24 documented an intervention that read skin inspection: monitor for redness, open areas .immediately report changes to the nurse .</p> <p>Review of Resident #71's care plan titled, [Resident name] has bladder incontinence due to functional decline, cognitive impairment and sepsis related to UTI initiated on 03/20/24 documented an intervention that read as monitor/document for s/sx (signs or symptoms of UTI: pain .change in behavior .</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>Review of Resident #71's Daily Skilled Nursing Flowsheet completed by Staff J, Registered Nurse (RN) dated 04/07/24, documented .Resident has had no pain this shift . was asked about level of pain .was observed for cognitive status this shift. Resident is alert this shift. has no short term memory problems and long term memory intact .Skin was also observed; Has no skin concerns skin is warm skin is dry skin is intact .</p> <p>Review of resident #71's Daily Skilled Nursing Flowsheet completed by Staff J, RN dated 04/08/24 documented .was observed for cognitive status this shift; Resident is alert this shift. Has no short term memory problems and long term memory intact . Skin was also observed; Has no skin concerns skin is warm skin is dry skin is intact .</p> <p>On 04/07/24 at 1:01 PM, observation revealed Resident #71 up pushing a wheelchair in her room and dragging the table with a lunch tray on top of the table with the wheelchair. At that time, the surveyor attempted to interview the resident who stated I need to go to my bed and my butt hurts. The resident asked surveyor what do I need to do? Observation revealed the resident was able to get back in bed.</p> <p>On 04/07/24 at 1:17 PM, Observation revealed Resident #71 out of bed, in a wheelchair attempting to go to her roommates area stating, where do I go now? moving in the wheelchair and stated, I want to go to bed, my butt hurts.</p> <p>On 04/07/24 at 1:18 PM, Staff N, Unit Manager was called in Resident #71's room. Staff N called Staff Q, CNA and put the resident in bed. Observation revealed Resident #71 continued to say, my butt hurts. Subsequently, Staff J, RN assigned to the resident was called in and stated the resident is always complaining of back pain. Staff J asked the resident Is your back hurting? the resident replied no, my butt hurts. Consequently, a side by side observation of the resident's buttocks was conducted with Staff Q, CNA and Staff J, RN. The observation revealed the resident had an adult brief with stool and her buttocks was observed with red, swollen and bump-like pimples. Staff J stated the resident had a brief rash and asked Staff Q, CNA to apply Zinc Oxide (barrier cream) available in her room.</p> <p>On 04/08/24 at 9:05 AM, observations revealed Resident #71 wheeling herself out of her room and wandering down the hallway.</p> <p>On 04/09/24 at 8:12 AM, a side by side review of Resident #71's Minimum Data Set (MDS) assessment was conducted with the MDS Supervisor. The review revealed an Admission assessment dated [DATE] with a documented Brief Interview of the Mental Status (BIMS) score of 9, indicating that the resident had moderate cognition impairment. The assessment documented that the resident needed partial to substantial assistance from the staff to complete her Activities of Daily Living (ADL) including functional mobility, toileting, shower, bathing and dressing. The MDS Supervisor confirmed the resident was not coded for any skin issues at the time of the assessment and there was no physician orders for skin impairment. The MDS Supervisor added the resident had left heel and lateral foot arterial wound that was resolved on 04/01/24 and stated the floor nurse does weekly skin checks on every resident</p> <p>On 04/09/24 at 8:39 AM, an interview was conducted Staff P, RN who stated she had not heard any skin issues for Resident #71 and did not have any skin medications orders for the resident. Staff P stated the CNA will let her know if the resident's has any skin rash so she will have the wound care nurse evaluate and then the physician is called.</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 04/09/24 at 8:42 AM, an interview was conducted with Staff R, CNA, assigned to Resident #71. Staff R stated she washed up Resident # 71 this morning and put zinc oxide to her buttocks, to protect the skin. Staff R stated she did not see any redness or rash on the resident's skin this morning.</p> <p>On 04/09/24 at 9:12 AM, an interview with Resident #71 was conducted and stated she wanted to go to the bathroom. Staff R was called in and was informed the surveyor would like to check the resident's skin. Staff R removed the resident's adult brief and stated she applied skin barrier (Zinc Oxide) this morning.</p> <p>On 04/09/24 at 9:21 AM, an interview was conducted with Staff N, Unit Manager (UM) who was apprised of Resident #71 complaining of buttock pain on 04/07/24 and her skin was noted with redness after a side by side check with Staff J, RN. Consequently, a side by side review of Resident #71 buttock's skin check was conducted with Staff N, UM and Staff R, CNA. Staff R stated it was a diaper rash. Staff N was asked to look lower and stated it was more than a diaper rash and added she will call the Wound Care Nurse (WCN) to check Resident #71's buttock's skin.</p> <p>On 04/09/24 at 2:59 PM, observation revealed the WCN and Staff N, UM checking Resident #71's skin. Subsequently, a joint interview was conducted with the WCN and Staff N. The WCN stated Resident # 71 had a fungal rash with some bumpy skin and redness on her sacrum and coccyx area; the WCN added the resident needs Lotrisone like cream. Staff N and the WCN were apprised that the resident complained of bottom pain on 04/07/24 and the physician was not made aware of. Staff N stated she was not aware of the resident's pain reported on 04/07/24.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</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 ensure that a resident receives wound care consistent with professional standards of practice for 1of 1 sampled residents reviewed for wound care (Resident #30).</p> <p>The findings included:</p> <p>Review of Resident #30's clinical record documented an admission to the facility on [DATE] with a readmission on 03/06/24. The resident's diagnoses included, in part, Atherosclerosis Heart Disease, Diabetes Mellitus Type 2, Peripheral Vascular Disease, Dysphagia, Atrial Fibrillation, Neuromuscular Dysfunction of the Bladder, Anxiety, Heart Failure, Depression, Sacral PU (pressure ulcer) stage 4 and [NAME] Prostatic Hyperplasia.</p> <p>Resident #30's Bowel and Bladder Evaluation dated 04/09/24 documented, the resident was incontinent of urine.</p> <p>Review of Resident #30's physician order dated 02/02/24 documented, cleanse sacrum (wound) with normal saline solution (NSS) and apply Collagen Powder to wound bed then pack with Calcium Alginate every day shift for pressure injury stage 4 -start date 02/02/24. Further review revealed that the physician order was discontinued on 03/05/24.</p> <p>Review of Resident #30's physician order dated 03/08/24 documented, cleanse sacrum (wound) with normal saline solution (NSS) and apply Calcium Alginate Ag. Cover with Silicone dressing every day shift for stage 4 pressure injury -start date 03/08/24.</p> <p>Review of Resident #30's physician order dated 04/08/24 documented, cleanse Right heel (wound) with NSS, dry well, apply Xeroform gauze, cover with dry dressing every day shift for Diabetic wound.</p> <p>Review of Resident #30's March 2024 Treatment Administration Record (TAR) documented, cleanse sacrum (wound) with normal saline solution (NSS) and apply Calcium Alginate Ag. Cover with Silicone dressing every day shift for stage 4 pressure injury -start date 03/08/2024.</p> <p>Review of Resident #30's April 2024 Treatment Administration Record (TAR) documented, cleanse sacrum (wound) with normal saline solution (NSS) and apply Calcium Alginate Ag. Cover with Silicone dressing every day shift for stage 4 pressure injury -start date 03/08/2024.</p> <p>Review of Resident #30's Wound Care Specialist notes dated 04/08/24 documented, Detailed Wound Evaluation .Present since 09/20/2023 .Assessment 1. Sacral stage IV pressure ulcer .Dressing Treatment Plan: clean wound bed with saline. Primary dressing: collagen powder and calcium alginate. Secondary dressing: Foam Silicone Dressing. Frequency: Daily and as needed .Plan of Care Reviewed and Addressed Coordination of Care: The treatment plan and care options were thoroughly reviewed and discussed during rounds with the nursing staff and the wound care team, ensuring a collaborative approach to the patient's care .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #30's Wound Care Specialist notes dated 04/02/24 documented, Detailed Wound Evaluation .Assessment 1. Sacral stage IV pressure ulcer. Dressing Treatment Plan: clean wound bed with saline. Primary dressing: collagen powder and calcium alginate. Secondary dressing: Foam Silicone Dressing. Frequency: Daily and as needed .Plan of Care Reviewed and Addressed Coordination of Care: The treatment plan and care options were thoroughly reviewed and discussed during rounds with the nursing staff and the wound care team, ensuring a collaborative approach to the patient's care .</p> <p>Review of Resident #30's Wound Care Specialist (WCS) notes dated 03/25/24 documented, Detailed Wound Evaluation .Assessment 1. Sacral stage IV pressure ulcer. Dressing Treatment Plan: clean wound bed with saline. Primary dressing: collagen powder and calcium alginate. Secondary dressing: Foam Silicone Dressing. Frequency: Daily and as needed .Plan of Care Reviewed and Addressed Coordination of Care: The treatment plan and care options were thoroughly reviewed and discussed during rounds with the nursing staff and the wound care team, ensuring a collaborative approach to the patient's care .</p> <p>Review of Resident #30's Wound Care Specialist notes dated 03/19/24 documented, Detailed Wound Evaluation .Assessment 1. Sacral stage IV pressure ulcer. Dressing Treatment Plan: clean wound bed with saline. Primary dressing: collagen powder and calcium alginate. Secondary dressing: Foam Silicone Dressing. Frequency: Daily and as needed .Plan of Care Reviewed and Addressed Coordination of Care: The treatment plan and care options were thoroughly reviewed and discussed during rounds with the nursing staff and the wound care team, ensuring a collaborative approach to the patient's care .</p> <p>On 04/09/24 at 7:20 AM, an interview was conducted with Resident #30 who stated the heel wound started last week and the staff was doing daily dressing changes. The resident agreed with surveyor wound care observation.</p> <p>On 04/09/24 at 7:43 AM, a side by side review of Resident #30's Minimum Data Set (MDS) quarterly assessment dated [DATE] was conducted with the MDS Supervisor. The review revealed the resident had a Brief Interview of the Mental Status (BIMS) score of 13, indicating that the resident has no cognition impairment. The assessment documented under Functional Status that the resident was dependent on staff for rolling, turning and transferring out of bed. During an interview, the MDS Supervisor stated that the resident has a diabetic wound on the right heel proximal developed on 04/04/24 and chronic stage 4 sacrum wound.</p> <p>Review of Resident #30's care plan titled, ADL (Activities of Daily Living) initiated on 02/26/22 and revised on 04/09/24 documented the resident requires assistance of two people with bed mobility, incontinence care and personal hygiene.</p> <p>Review of Resident #30's care plan titled Alteration skin-actual related to pressure, incontinence, Diabetes Mellitus and Peripheral Vascular Disease initiated on 05/07/22 and updated on 01/20/24 documented interventions to include: administer treatments/medications as ordered .notify nurse immediately of any new areas of skin breakdown: redness discoloration noted during bath or daily care .</p> <p>On 04/09/24 at 2:06 PM, wound care observation started for Resident #30 performed by the facility's dedicated Wound Care Nurse (WCN) and assisted by Staff S, CNA. During an interview, the WCN stated the resident had a new facility acquired diabetic wound on the right heel and a chronic sacrum wound stage 4, and the resident needed to be turned and repositioned every two hours by the staff.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation revealed the WCN disinfected the resident's table, performed hand hygiene, gathered the wound care supplies, donned a gown, entered the resident's room, performed hand hygiene and donned gloves. Further observation revealed Staff S, CNA was providing care to the resident and was not wearing a gown, as required. Furthermore, observation revealed Resident #30 had two briefs on. Consequently, an interview was conducted with Staff S who stated the resident pees a lot and needed a dressing change. Staff S was asked if she just put the brief on and replied she just started her shift and did not put two briefs on Resident #30. Staff S stated she does not put two briefs on any resident and does not put a gown on when providing care to Resident #30.</p> <p>On 04/09/24 at 2:30 PM, observation revealed the WCN removed Resident #30's right heel dressing. The dressing had a small amount of sero-sanguinolent drainage, no odor. The WCN removed her gloves, performed hand washing, donned gloves and cleaned the resident's right heel wound. Further observation revealed the WCN, with the same pair of gloves she cleaned the wound with, proceeded to apply a piece of Xeroform gauze and covered it with a dry dressing.</p> <p>On 04/09/24 at 2:36 PM, continued wound care observation for Resident #30 was conducted. The WCN gathered the following wound supplies: calcium alginate, normal saline solution and a border dressing) to performed the resident's sacrum wound care. The WCN entered the resident's room, performed hand hygiene, donned gloves and a gown. Observations revealed the WCN cleaned the resident's sacrum wound with normal saline solution and with same pair of gloves she cleaned the wound, the WCN packed the wound by pushing a piece of Calcium Alginate into the wound with her index finger and covered with dry dressing. Further observation revealed resident #30's bottom had redness to the bottom and buttocks. The WCN was asked if the resident's rash had been addressed and stated the resident was not getting any treatment for it at that time. The WCN stated it was a fungal rash and will call the physician for new orders.</p> <p>On 04/09/24 at 2:50 PM, after wound care was completed an interview was conducted with the WCN who was apprised of the findings noted above. The WCN stated she changed her gloves after cleaning the wound.</p> <p>On 04/10/24 at 1:45 PM, an interview was conducted with Staff T, Registered Nurse (RN) who stated she was not aware of Resident #30's bottom or buttock redness.</p> <p>Review of Resident #30's Daily Skilled Nursing Flowsheet dated 04/08/24, completed by Staff T documented .Skin was also observed; Has no skin concerns. skin is warm skin is dry .ADL care was provided this shift .</p> <p>Review of Resident #30's Daily Skilled Nursing Flowsheet dated 04/09/24 completed by Staff T, RN documented .Skin was also observed; Has no skin concerns .</p> <p>On 04/10/24 at 1:48 PM, during an interview, the Director of Nursing (DON) was apprised of the wound care observations. The DON stated the WCN missed a step by not changing her gloves after she cleaned the wound.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/10/24 at 2:08 PM, a joint interview was conducted with the Director of Nursing (DON) and the WCN. The WCN was apprised that the WCS assessment/plan documented to apply collagen powder and calcium alginate to the sacrum wound and she did not apply the collagen powder during the wound care observation for Resident #30 on 04/09/24. The WCN stated she had been applying the collagen powder to the wound but looked at the physician order prior to the surveyor wound care observation and did not see the collagen powder as part of the order. The WCN stated the WCS had been applying the collagen to the sacrum wound.</p> <p>On 04/10/24 at 2:03 PM, a conference call with the DON, WCN and the WCS was conducted. The WCS stated that Resident #30 had a small sacral wound that is improving, responding to collagen and calcium alginate. The WCS stated his wound care orders was to apply collagen powder and calcium alginate daily. The WCS was apprised that the collagen powder was not applied during Resident #30's wound care observation. The WCS stated he discusses and goes over each dressing change, every visit.</p> <p>On 04/10/24 at 2:30 PM, during an interview, the WCN she stated that on 03/05/24 she discontinued in error, the physician order for cleanse sacrum (wound) with normal saline solution (NSS) and apply Collagen Powder to wound bed then pack with Calcium Alginate every day shift for pressure injury stage 4.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349</p> <p>Based on review of policy and procedure, observation, interview and record review, the facility failed to ensure that it performed appropriate hand hygiene, care and cleanliness to avoid cross-contamination, per professional standards, during Perineal and Foley Catheter care for 1 of 1 sampled residents observed, (Resident #97).</p> <p>The findings included:</p> <p>Review of the facility policy and procedure provided by the Director of Nursing (DON), titled, 'Perineal Care' revised February 2018, documented in the Policy Statement: Purpose: the purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition For a female resident: (2) Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth.</p> <p>Review of the un-dated facility policy and procedure provided by the DON, titled, 'Infection Control' related to Perineal Care, revised February 2018, documented in the Policy Statement: Infection Control during perineal care (pericare) is crucial to prevent the transmission of infections, protect the patient's skin integrity, and maintain overall hygiene. Pericare involves cleaning the genital and anal areas, which can harbor bacteria and other pathogens. Proper technique and adherence to infection control principles are essential during this sensitive procedure. Here are the key infection control measures to follow during perineal care: 1. Hand Hygiene: Perform hand hygiene before and after providing pericare. Use soap and water or an alcohol-based hand rub to reduce the transmission of microorganisms .Following these infection control measures during perineal care can significantly reduce the risk of infection and promote comfort and dignity for the patient.</p> <p>Resident #97 was readmitted to the facility on [DATE] with diagnoses which included Rhabdomyolysis, Acute Kidney Failure, Diabetes Mellitus Type II, Chronic Diastolic (Congestive Heart Failure), Obstructive Uropathy, Neuromuscular Dysfunction of Bladder, Dementia, Anemia, Depression, Hypertension and Cardiac Pacemaker. She had a Brief Interview Mental Status (BIM) score of 3 (severely impaired).</p> <p>During a Foley catheter/Peri-care observation of Resident #97, conducted on 04/09/24 at 10:24 AM, Resident #97 was observed resting in bed with the head of the bed elevated. The urine color in the Foley catheter was noted to be hazy yellow and slightly cloudy; with a blue privacy bag, in place. The Foley catheter was observed to be properly anchored in place.</p> <p>Peri-care was observed being performed by Staff K, Certified Nursing Assistant (CNA). Staff K, was assisted by Staff I, a Restorative CNA, who were both observed initially washing their hands for 35-40 seconds before beginning care. Resident #97 provided permission for this surveyor to observe her peri-care.</p> <p>(continued on next page)</p>		

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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	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Staff K, was not observed allowing the resident to first test the water with her fingers to ensure that it was at a comfortable temperature. The resident's privacy curtain was first pulled closed by staff. Staff K, gathered her supplies and donned a clean pair of gloves. Staff K, used both towel wash cloths as well as a package of Adult Washcloths, single hand dispensing, Alcohol-free and Latex-free. Staff K, began wiping/washing the resident's peri-area from front to back first (on each separate side of the resident's labia) while the resident was lying on her back.</p> <p>Resident #97 was observed to have had a bowel movement (BM) during the Foley catheter/peri-care. However, Staff K, was not observed removing her dirty gloves, sanitizing her hands and changing to a fresh pair of gloves, after she had cleaned the feces off the resident. Staff K, then proceeded to begin using the same pair of gloves to wash and rinse the resident's peri area, using the same basin with water, without changing out the dirty basin of water, in between use.</p> <p>Afterwards, Staff K, then grasped the Foley catheter tubing using a clean washcloth and pulled/cleaned the tubing, at the base, away from the labia in two separate steps. Staff K, was only observed removing and changing to a fresh pair of gloves, and utilizing hand sanitizer, prior to drying the resident's peri area, subsequent to continuing the care.</p> <p>Finally, Staff K, then removed the old gloves and washed her hands and applied a clean pair of gloves and then she turned the resident and gently cleaned and dried her buttock area from front to back with Adult Washcloths, single hand dispensing, Alcohol-free and Latex-free. Staff K, was observed changing the resident's diaper, and both clothing and bedding were changed as well. Afterwards, Staff K, washed her hands again for 35-40 seconds.</p> <p>On 10/11/23 the care plan documented---Focus: [Resident #97] has a Foley catheter related to bladder outlet obstruction----Neurogenic Bladder. Interventions: .Monitor for signs and symptoms of discomfort on urination and frequency .Monitor/record/report to MD for signs and symptoms Urinary Tract Infection: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul-smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns.</p> <p>On 04/09/24 at 10:57 AM, an interview was conducted with Staff K, in which she acknowledged that her gloves should have been changed, her hands should have been sanitized, and the rinse water changed, after a resident has a BM, prior to performing peri and Foley catheter care on the resident.</p> <p>On 04/09/24 at 11:17 AM, an interview was conducted with Staff L, Registered Nurse (RN)/Unit Manager of the [NAME] Unit, in which she also acknowledged that Staff K, should always change her gloves, sanitize her hands and change the rinse water after a resident has a BM, prior to performing peri and Foley catheter care on the resident.</p> <p>The DON further recognized and acknowledged that 04/09/24 11:37 AM that Staff K, should always change her gloves, sanitize her hands, and change the rinse water after a resident has a BM, prior to performing peri and Foley catheter care on a resident; this was not done.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057</p> <p>Based on observation, interview and review of policy and procedure, the facility failed to:</p> <ol style="list-style-type: none"> 1) ensure that residents medications were properly stored, as evidenced by over the counter medications being left in the resident's room for 5 of 5 sampled residents (Resident #119, #474, #473, #475, and #476); 2) ensure that residents prescription medication were properly stored at the B-wing, as evidenced by medications being left in a medication cup in the resident's room (Resident #129) 3) ensure that resident's medication were stored properly, as evidenced by an opened bottle of Nitroglycerin tablets being left in a drawer at the C-wing nurses station. 4) ensure that it secured 2 of 3 wound care supply carts, located in the C and D wing. <p>The findings included:</p> <p>Review of the facility's policy titled, Medication Labeling and Storage with no revision dated provided by the Director of Nursing documented The facility stores all medications .in a locked compartments .the nursing staff is responsible for maintaining medication storage .</p> <p>1) Review of Resident #119's clinical record documented an admission to the facility on [DATE] and a readmission on 02/13/24. The resident's diagnoses included Left Femur fracture, Heart Failure, Hypertension, Diabetes Mellitus Type 2, Atrial Fibrillation and History of Falling.</p> <p>On 04/07/24 at 12:03 PM, during the initial tour, observations revealed Resident #119 in bed, with her eyes open. She was alert and oriented. Further observation revealed an Aspercreme- Lidocaine roll on bottle on top of the resident's table. An interview was conducted with the resident who stated she was using it at home for her knee pain and asked her daughter to bring it in. Resident #119 stated the nurses were not aware of the Aspercreme roll-on bottle in her room.</p> <p>On 04/08/24 at 9:00 AM, an interview was conducted with Staff O, Registered Nurse (RN) who stated the residents were not supposed to have medications in their room and if she sees a medication in the room, she will interview the resident, will remove it and call the physician. Staff O stated she had not seen medications in the resident's room.</p> <p>On 04/08/24 at 2:48 PM, a side by side observation of Resident #119's night stand and table was conducted with Staff J, RN. The resident was not in her room. The Aspercreme roll-on bottle was not on the table. Photographic evidence was shown to Staff J, RN. Staff J stated the resident was not supposed to have the medication in her room.</p> <p>Review of Resident #119's physician orders lacked written evidence of an order for self-administration of Aspercreme-Lidocaine medication.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #119's clinical record lacked written evidence of a self-administration of medications assessment or a care plan.</p> <p>2) Review of Resident #473's clinical record documented an admission to the facility on [DATE] and no readmissions. The resident's diagnoses included Cervical Disc Disorder, Diabetes Mellitus Type 2, Atrial Fibrillation and Hypertension.</p> <p>On 04/08/24 at 12:15 PM, observation revealed a bottle of Clear-Lax powder (a laxative) on top of Resident #473's table. An interview was conducted with the resident who stated he takes Miralax (same as Clear-Lax) every day.</p> <p>On 04/08/24 at 2:45 PM, an interview was conducted with Staff J, RN who was apprised of Resident #473 having a bottle of Clear-Lax bottle in his room. Staff J stated she saw the bottle in the room and told the resident to put it away. Staff J was showed that the Clear-Lax was still on top of the resident's table. During the review, Staff J stated the resident was not supposed to have it in the room and added that the resident was on Lactulose (a laxative) that will help him.</p> <p>Review of Resident #473's physician orders revealed an order dated 03/21/24 for Polyethylene Glycol Powder (same as Clear-Lax) to give 17 gram once a day for constipation. The record lacked written evidence of a physician order for self-administration of Clear-Lax medication.</p> <p>Review of Resident #473's clinical record lacked written evidence of a self-administration of medications assessment or a care plan.</p> <p>3) Review of Resident #474's clinical record documented an admission to the facility on [DATE] and no readmissions. The resident's diagnoses included Traumatic Subdural Hemorrhage, Seizures, Depression and Insomnia.</p> <p>On 04/07/24 at 10:45 AM, observation revealed Resident #474 in bed. Observation revealed a round white pill on top of the resident's night stand and a medication container with a community pharmacy label with another person's name and the word TUMS written on the label. An interview was conducted with the resident who stated the medication container had TUMS in it and that he did not use it.</p> <p>On 04/07/2024 at 10:56 AM, an interview was conducted with Staff J, RN who stated that when she administer medications to the residents, she will stay until the resident take them. Subsequently, a side by side review of the white round pill and TUMS bottle on Resident #474's night stand was conducted with Staff J who stated the white pill was not given by her and added that she only had one pill for Resident #474 and it was not a white round pill. Staff J removed the TUMS bottle and told the resident that if he needs TUMS to ask for it.</p> <p>Review of Resident #474's physician orders lacked written evidence of an order for TUMS chewable. The record lacked written evidence of a physician order for self-administration of TUMS chewable.</p> <p>Review of Resident #474's clinical record lacked written evidence of a self-administration of medications assessment or a care plan.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4) Review of Resident #475's clinical record documented an admission to the facility on [DATE] and no readmissions. The resident's diagnoses included Multiple Fractures of Ribs, Pleural Effusion, Fibromyalgia and Hypertension.</p> <p>Review of Resident #475's physician orders lacked written evidence of an order for 8-Hour Arthritis Pain Acetaminophen 650 milligrams medication. The record lacked written evidence of a physician order for self-administration of 8-Hour Arthritis Pain Acetaminophen medication.</p> <p>Review of Resident #475's clinical record lacked written evidence of a self-administration of medications assessment or a care plan.</p> <p>On 04/07/24 at 1:05 PM, observation revealed Resident #475 in the room sitting in a wheelchair eating lunch. Observation revealed a bottle of 8-Hour Arthritis Pain Acetaminophen 650 milligrams medication on top of her table and unsecured. An interview was conducted with the resident who stated the 8-Hour Arthritis Pain Acetaminophen 650 milligrams medication was brought in to her by her neighbor and was not sure if the nurse knew about it. The resident stated she takes it at night and added she fell and had ribs fracture.</p> <p>Further observation revealed Resident #71, her roommate, who had a diagnosis of Dementia, was walking in her room, exit seeking, confused, saying she did not know where to go. Observation revealed Resident #71 got closer to Resident #475 table where the unsecured medication was observed and Resident #475 told the resident to go to bed.</p> <p>On 04/08/24 at 12:25 PM, observation revealed Resident #475 was not in her room and the bottle of 8-Hour Arthritis Pain Acetaminophen 650 milligrams medication continued to be on top of the table and unsecured. Furthermore, Resident #71 was in the room alone.</p> <p>On 04/08/24 at 2:50 PM, a side by side review of Resident #475 table was conducted with Staff J, RN. Staff J confirmed the resident had a bottle of 8-Hour Arthritis Pain Acetaminophen 650 milligrams medication on top of the table. The resident was in bed and stated it was convenient to have it in her room.</p> <p>5) Review of Resident #476's clinical record documented an admission to the facility on [DATE] and no readmissions. The resident's diagnoses included Multiple Fractures of Ribs, Malignant Neoplasm of Right Breast and Lung, Generalized Anxiety Disorder and Fibromyalgia.</p> <p>Review of Resident #476's physician orders lacked written evidence of an order for Dry Eye Relief Lubricant and prescription medication Azelastine Hydrochloride nasal spray.</p> <p>The record lacked written evidence of a physician order for self-administration of Dry Eye Relief Lubricant and prescription medication Azelastine Hydrochloride nasal spray.</p> <p>Review of Resident #476's clinical record lacked written evidence of a self-administration of medications assessment or a care plan.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/07/24 at 11:27 AM, observation revealed Resident #476 in bed. An interview was conducted with the resident who stated that she felt nauseated and wanted to throw up. Further observation revealed a box of Dry Eye Relief lubricant and a prescription medication- Azelastine Hydrochloride nasal spray on the window sill. The resident stated she had used the nasal spray medication twice since she was in the facility and that the nurses were aware of that.</p> <p>On 04/08/24 at 3:19 PM, during an interview, Staff N, Unit Manager (UM) was apprised of Resident #119, #474, #473, #475, and #476 observed having over the counter medication and prescription medication in their room without a physician order. Staff N stated the residents were not supposed to have any medications in their room and added the nurses make rounds but family members bring them over the counter medications to them. Staff N stated none of the sampled residents had a self-administration of medications assessment done. Photographic evidence shown to Staff N, Unit Manager.</p> <p>38349</p> <p>6) Resident #129 was admitted to the facility on [DATE] with diagnoses which included Dementia, Type 2 Diabetes Mellitus, Essential (Primary) Hypertension, Chronic Kidney Disease, Stage 3 Unspecified, Mood Disorder due to Known Physiological Condition, Unspecified, Wandering in Diseases and Atherosclerotic Heart Disease of Native Coronary Artery. She had a Brief Interview Mental Status (BIMs) score of 4 (severely impaired).</p> <p>On 04/07/24 at 9:45 AM, during an observational room tour, Resident #129's room was observed with four (4) different tablets later identified as Namenda 10mg one (1) tablet BID due 5 PM, Metformin 500mg one (1) tablet BID due 5 PM, Donepezil 10mg (1) tablet at bedtime due 9 PM and Quetiapine 50mg one (1) tablet BID due 5 PM, observed in a medication cup, all exposed, accessible and unattended on the resident's bedside table, to other residents, staff members and visitors, for well over seventeen (17) hours, from the previous 3-11:30 PM shift. Photographic Evidence Obtained.</p> <p>During a brief interview conducted with Resident #129 on 04/07/24 at 9:47 AM, who had been in the bathroom and exiting it at the time, she was asked about the pills. She initially stated that they were not her medications. But, she later added that she knew or believed that they were placed there in the medication cup, but she said that she was unsure and she was not going to take them.</p> <p>An interview was conducted on 04/07/24 at 9:56 AM with the resident's nurse, Staff M, Licensed Practical Nurse (LPN), in which she was asked who left the pills at the resident's bedside, what pills were they and why were they left there, unattended. Staff M, initially responded that she did not administer any medications to this resident this morning. Staff M, stated that she did make morning rounds with the on-coming nurse in this resident's room, however, she indicated that the light was off, and the room was dark, at the time. Staff M, further stated the four (4) pills must have been left there at Resident #129's bedside during the 3-11:30 PM shift the evening before. Staff M compared the actual pill medications with numbers and colors with the physician orders and she indicated that they were all prescription medications and she acknowledged that the prescription pill medications should not have been left unattended at the Resident #129's bedside.</p> <p>Side-by-side record review was conducted with Staff M, in which it was noted that neither Resident #129's hard copy chart nor her computerized Point-Click-Care (PCC) medical record indicated that the resident had any self-assessment completed in order for her to be able to administer her own medications.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/07/24 at 10:02 AM an interview was conducted with the Registered Nurse (RN)/Assisted Director of Nursing (ADON), in which she also acknowledged that the pill medications should not have been left unattended at the resident's bedside.</p> <p>The medication cup containing the four (4) pills was not removed from Resident #129's bedside, until after surveyor inquisition/intervention.</p> <p>7) During observational tour on 04/09/24 at 10:14 AM it was noted that there was an unsecured, visible, unattended twenty-three (23) of twenty-five (25) pill bottle of Nitro sublingual (SL) tablets 0.4 mg per tablet with an expiration date of 06/2025 observed at the Cambridge Nurses' station in an open drawer.</p> <p>On 04/09/24 at 10:16 AM, both the Assistant Director of Nursing (ADON) and the DON were made aware of the above and they both recognized and acknowledged that the bottle of Nitroglycerin tablets should not have been there and should have been secured.</p> <p>49060</p> <p>8) During the initial tour of the facility conducted on 04/07/24 at 11:15 AM, the surveyor noted an unlocked treatment cart on the D-Unit Hallway of the facility, photographic evidence obtained. Upon further inspection, there were resident-specific treatment medications stored in the top drawer of the wound care cart. During this observation, multiple staff members, residents, and visitors were noted walking past the treatment cart.</p> <p>During an interview conducted on 04/10/24 at 11:28 AM with the Wound Care Nurse. She stated that each unit has a designated wound care cart, and all Unit nurses have the keys to the treatment cart. In addition, she stated that on the weekends, wound care treatments are done by the unit nurses.</p> <p>During another tour of the facility conducted on 04/10/24 at 1:35 PM, the surveyor again noted an unlocked treatment cart located on the C-Unit of the facility, photographic evidence obtained. Upon further inspection of the top drawer of the wound care cart revealed treatment medications labeled with resident's names and a pair of scissors. During this observation, multiple staff members, residents, and the Assistant Director of Nursing (ADON) were noted walking past the treatment cart.</p> <p>During an interview conducted on 04/10/24 at 1:36 PM with ADON. She stated that all medication and treatment carts should be locked. In addition, she stated that she will follow up with all the nursing staff.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to follow the approved menu for physician ordered Regular Diets for 133 residents (including sampled Resident's #112, #162, #119), Mechanical Altered Chopped Diets for 24 residents (including sampled Residents #14, #17, #29, and 97), Mechanical Altered Ground Diets for 3 residents (including sampled Resident #116) , and Pureed Diets for 10 residents (including sampled Residents #7 and #92).</p> <p>The findings included:</p> <p>1) During the review of the facility's approved menu for the lunch meal of 04/07/24 , the following were noted to be served:</p> <ul style="list-style-type: none"> * Dinner Roll-Regular Diet * Chopped Dinner Roll-Mechanical Altered Chopped Diet * Pureed Dinner Roll-Mechanical Altered Ground Diet, and Pureed Diet <p>< Observation of the lunch meal in the main kitchen on 04/07/24 at 11:30 AM, noted the following:</p> <ul style="list-style-type: none"> * Dinner Roll-not available, no dinner roll substitute served * Chopped Dinner Roll-not prepared , no substitute prepared * Pureed Dinner-not prepared, no substitute prepared <p>Interview with the Lunch Cook (Staff A) at the time of the meal service noted to state she did not have an approved menu and failed to prepare and serve Dinner Roll, Chopped Dinner Roll, and Pureed Dinner Roll.</p> <p>2) During the review of the facility's approved menu for the breakfast meal of 04/08/24, the following were noted to be served:</p> <ul style="list-style-type: none"> * [NAME] Bread-Regular Diet * Chopped [NAME] Bread-Mechanical Altered Chopped Diet * Pureed [NAME] Bread-Mechanical Altered Chopped Diet, and Pureed Diet <p>< Observation of the breakfast meal conducted in the main kitchen on 04/08/24 at 7:30 AM, noted the following:</p> <ul style="list-style-type: none"> * Whole Wheat Bread - [NAME] Bread not available <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>* Chopped [NAME] Bread-not available, and no substitute prepared</p> <p>* Pureed [NAME] Bread-not available, and no substitute prepared</p> <p>* Pureed [NAME] Bread-not available, and no substitute prepared</p> <p>3) During the review of the approved menu for the facility's lunch meal of 04/08/24, the following were noted to be served:</p> <p>* Chopped Dinner Roll-Mechanical Altered Chopped Diet</p> <p>* Pureed Dinner Roll-Mechanical Altered ground Diet and Pureed Diet</p> <p>* Mandarin Oranges-Regular Diet and Mechanical Altered Chopped Diet</p> <p>* Pureed Mandarin Oranges-Pureed Diet</p> <p>< Observation of the lunch meal conducted in the main kitchen on 04/08/24 at 11:30 AM noted the following to be served</p> <p>* Chopped Dinner Roll-not prepared, and no substitute served</p> <p>* Pureed Dinner Roll-not prepared, and no substitute served</p> <p>* Mandarin Oranges-not available, and apple pie substituted</p> <p>* Pureed Mandarin Oranges-not available, and pureed apple pie served</p> <p>Interview with the Lunch Cook (Staff A) at the time of the meal observation noted the approved menu was not available during the preparation of the lunch meal and further stated an incorrect menu was posted for the staff to follow.</p> <p>4) Review of the facility's Diet Census dated 04/07/24 the following was noted:</p> <p>* Physician ordered Regular Diet (133 residents, including sampled Resident #112, #162, and #119).</p> <p>* Physician ordered Mechanical Altered Chopped Diet (24 residents, including sampled Residents #14, #17, #29, and 97).</p> <p>* Physician ordered Mechanical Altered Ground Diet (3 residents, including sampled Resident #116).</p> <p>*Physician ordered Pureed diet (10 residents, including sample Residents #7 and #92).</p> <p>38893</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5). Resident #7 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly Minimum Data Set Assessment, Resident #7 was not assessed for cognition due to 'resident is rarely/never understood'. The assessment documented that Resident #7 was dependent upon staff for all activities of daily living, including eating and was 'always incontinent' of bowel and bladder with no devices. Resident #7's diagnoses at the time of the assessment included: Coronary Artery Disease, Hypertension, Diabetes Mellitus, Alzheimer's Disease, Non-Alzheimer's Dementia, Traumatic Brain Injury, Depression, Presence of Cardiac Pacemaker, Hypothyroidism, Dysphagia, History of Malignant Neoplasm of Prostate, and History of Malignant Neoplasm of Kidney.</p> <p>Resident #7's Dietary orders included:</p> <p>CCD (Cardiac Controlled Diet) & NAS (No Added Salt), Puree texture, Nectar Thickened Liquids consistency - 08/23/23.</p> <p>Prune juice 3 ounces WITH BREAKFAST - 03/24/23.</p> <p>On 04/08/24 at 9:27 AM, Resident #78 was being fed breakfast by Staff X, CNA (Certified Nursing Assistant). It was noted that Resident #7 did not receive the nectar thick prune juice as ordered. When Staff V was asked about the order for the prune juice, Staff V stated that the resident did not receive prune juice as ordered.</p> <p>During an interview, on 04/08/24 at 11:10 AM with Staff U, Licensed Practical Nurse (LPN), the Staff U stated, he is not able to eat or drink himself, his wife and the staff have to assist him and feed him.</p> <p>During an observation of breakfast served that had been removed from residents' rooms, on 04/10/24 10:12 AM, it was noted that Resident #7 consumed 100% of the food and there was no evidence that the resident received the prune juice as ordered. Review of the tray ticket that accompanied the meal revealed that the order for prune juice was not reflected on the tray ticket.</p> <p>During an interview, on 04/10/24 at 10:46 AM, with the Dietary Supervisor and Regional Director of Food and Nutrition Services, the Dietary Supervisor confirmed that the order for prune juice was not reflected on the tray ticket. The Dietary Supervisor stated that if it is not on the tray ticket then the item would not be served to the resident. The Dietary Supervisor stated, We have it in the back in 3 oz containers and the thickener to make it nectar thick.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>01948</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to prepare food by methods that conserve methods that conserve nutritive value, flavor, and appearance for 10 physician ordered pureed diets(including sampled Residents #7 and #92), 24 physician ordered Mechanically Altered Chopped Diet (including sampled Residents #14, #17, #29, #29, and #97), and 3 physician Mechanically Altered Ground Diet (including sampled Resident #116).</p> <p>The findings included:</p> <p>During the initial kitchen/food service observation tour conducted on 04/07/24 at 10 AM, it was noted that foods were being prepared in the small food preparation room by the Lunch Cook (Staff B). Further observation noted a large food preparation located on top of the stove top. Further investigation noted that the pan contained approximately 40 pounds of green beans that were boiling and were fully cooked and were also noted to begin breaking apart from overcooking.</p> <p>It was also noted that the oven contained a full steam table sized pan of Baked Vegetarian Ziti, and full pan of 20 fully cooked Vegetable Burgers.</p> <p>Interview conducted with Staff B at the time of the 10 AM observation noted to state that the fully cooked Green Beans, Ziti, and Vegetable Burgers were prepared at 10 AM for the dinner meal. Staff B further stated the foods are cooked early to be able to puree, chop , and ground foods for mechanically altered diets. Staff B further stated that all dinner foods that require puree, chopped, and ground are prepared daily by 10 AM for the dinner meal. It was also noted that after the preparation the prepared foods are held in the oven at high temperatures until the 4:30 PM dinner tray line start time. Further interview noted that Staff B was unaware that prolonged cooking and high heat holding would negatively effect the foods nutritive value, appearance, and palpability. Staff B stated that he had not had any formal training by the facility for quality food preparation standards.</p> <p>A review of the facility's diet census for 04/07/24 noted the following:</p> <ul style="list-style-type: none"> * 10 facility residents with physician ordered pureed diet which included sampled Resident #7 and #92, * 24 facility residents with physician ordered Mechanical Altered Chopped Diet which included sampled Resident's #14, #17, #29, and #97. * 3 facility residents with physician ordered Mechanically Altered Ground Diet which included sampled Resident #116. 		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>01948</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to prepare food in a proper pureed form to meet the needs of 10 facility residents with physician ordered Pureed Diet which included Sampled Resident's #7 and #92.</p> <p>The findings included:</p> <p>Review of the facility's Approved Diet Manual- Care Rite Diet Manual for Health Care Communities - 2023-</p> <p>* Pureed Diet noted:</p> <p>Indicated for difficulty in chewing or swallowing food items. Food are pureed in a blender or food processor to leave a smooth (pudding like texture) without lumps of large chunks. Nothing that required chewing is allowed. Pureed foods should be of one consistent texture and upon testing, fall off a spoon as an intact spoonful, and hold it's shape on a plate.</p> <p>* Review of main kitchen posting of (Pureed Diet noted:</p> <p>< All foods must be:</p> <p>* Pureed</p> <p>* Homogenous</p> <p>* Cohesive</p> <p>* Pudding-like</p> <p>* Requires no chewing</p> <p>During the observation of the lunch meal in the Main Kitchen on 04/07/24 at 11:30 AM, hot foods located on the steam tables were viewed by the surveyor. Observation of the pureed foods noted that the pureed rice had visible lumps and large pieces of rice within the pureed mixture. At the request of the surveyor the pureed rice mixture was taste tested for consistency by the surveyor and the Food Service Director (FSD). The taste test of the pureed meal revealed large lumps and pieces of rice by the surveyor and FSD. The surveyor requested that the pureed rice mixture not be served to physician ordered pureed diets and to puree the rice until the proper pureed consistency is achieved.</p> <p>An interview conducted with the Lunch Cook (Staff A) at the time of the observation noted that she does not taste test pureed food for proper homogenous smooth consistency and was unaware that resident with a diagnoses of swallow deficiency and dysphagia can choke or aspirate on small foods during swallowing. The surveyor requested to the FSD and facility's Registered Dietitian that a policy be developed to ensure that foods are properly prepared for all meals.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the review of the facility's Diet Census for 04/07/24 noted that there were 10 facility residents with physician ordered Pureed Diet. Further review noted that the 10 facility residents included Sampled Resident #7 and #92.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01948</p> <p>Based on observation and interview, it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>The findings included:</p> <p>During the initial Food Service Observation Sanitation Tour conducted on [DATE] ay 8:40 AM, and subsequent tours conducted on [DATE] at 7 AM and 11:30 AM with the Foods Service Director, and [DATE] at 11:30 AM, accompanied with the Corporate Dietary Manager, the following were noted:</p> <p>1) [DATE] (8:40 AM Tour):</p> <ul style="list-style-type: none"> * Large uncovered cart full of uncovered soiled resident food trays located at the entrance to the dietary department. The uncovered soiled trays were from the prior dinner meal. * Two staff working in the food production area noted to have facial beards that were not covered from contaminating foods. Surveyor requested to don beard guards prior to continue working within the department. * During the temperature testing of the hot and cold foods it was noted that serving staff failed to have a supply of alcohol wipes to properly sanitize the digital food thermometer. Staff were noted to be wiping the thermometer stem with a soiled napkin. The surveyor requested the staff to cease cleaning the thermometer between foods with the contaminated paper napkin. * The mounted cutting board that was attached to the steam table was noted to have deep cut grooves that were full of black mold type matter. * A temperature test conducted with the facility's calibrated thermometer of juices located on the food tray line assembly were noted to be not held at the minimum requirement of 41 degrees F or below as evidenced by: <ul style="list-style-type: none"> < Apple Juice (30 - 4 ounce portions) = 61 degrees F . Surveyor directed staff to not serve, < Cranberry Juice (50 - 4 ounce portions) = 65 degrees F. Surveyor directed staff to not serve. < Ten - 4 ounce portions of Cottage Cheese = 62 degrees F. Surveyor directed staff to not serve. * Food transportation carts (3) located on the tray assembly line were noted to be heavily soiled and large areas of dried food matter. * The interior shelves (6) of the Victory reach-in refrigerator were noted to be soiled, in disrepair, and rust laden. The refrigerator was also noted to fail to have an operational thermometer located with the unit. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>* The shelving which houses juice concentrate containers (3) were noted to be full of thick/sticky juice concentrate that appeared to be dripping from the containers of apple, cranberry , and orange juice.</p> <p>* The interior spout of the juice dispensing gun was noted to be full of dried fruit juice matter that was turning black mold in color.</p> <p>* Two bench mounted commercial can openers were noted to be covered with dried food matter that appeared to be a black mold type matter and tiny shaved pieces of aluminum cans. Surveyor directed the cook not to utilize the openers until they were properly cleaned and sanitized.</p> <p>* The commercial blender was noted to have stagnant water (1 inch) inside of the unit. Surveyor requested the cook to not use the blender until properly cleaned, sanitized, and drained.</p> <p>* The exterior of the electric panel that was attached to the food preparation counter was rust laden.</p> <p>* The interior cavity's (2) and doors (4) were heavily soiled and a heavy build-up of black carbon matter.</p> <p>* The interior cavity of the commercial ice machine was noted to soiled and areas of peeling paint. The ice located within the unit was potentially contaminated.</p> <p>* The hand wash sink basin was noted to be soiled and the drain area was rust laden.</p> <p>* The utility drawer of which food serving utensils were being stored was noted to not have the utensils stored in a sanitary manner to ensure that the serving stems are not contaminated.</p> <p>* A chemical testing of the two 3-compartment sinks was noted to fail to have the regulatory requirement of the level of sanitizing chemical present in the sinks.</p> <p>* The interior and exterior surfaces of the preparation skillets (10) were noted to have the Teflon surfaces wearing off and were layered with a thick black carbon substance. Each time the skillets are used could potentially result in food contamination.</p> <p>* The interior of the dish machine was noted to be soiled and heavy build-up of water lime substance. The machine was not being properly cleaned between meals and was not being de-limed on a regular basis.</p> <p>* Observation of the walk-refrigerator noted:</p> <p>< 2 flats of non-pasteurized raw eggs (4 dozen) that contained numerous broken eggs and a heavy build-up of black mold on top of the egg shell exteriors.</p> <p>< Four - 5 pound containers of Cottage Cheese that were expired with a manufacturers stamped expiration dates of [DATE] (3) and [DATE] (1) .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>< Three - 5 pound containers of Greek Yogurt that had expired with a manufacturers stamped expiration date of [DATE].</p> <p>< Expired prepared foods that included: Egg Salad Platters (6) with preparation date of [DATE], and Tuna Salad Platters (6) with preparation date of [DATE].</p> <p>< The surveyor requested that the Cottage Cheese, Greek Yogurt and salad platter not be served and to be discarded.</p> <p>* Observation of the Walk-in freezer noted that a box of Veggie Burgers (20 left) was not properly covered that resulted in the burgers to to be freezer burned and should not be prepared and served .</p> <p>Photographic Evidence Obtained.</p> <p>2) [DATE] (11:30 AM Tour):</p> <p>< A chemical testing of cleaning cloth buckets (4) located throughout the food service preparation and serving area were noted to have an insufficient level of chemical (Quaternary) to meet the regulatory requirement .</p> <p><During the observation of the lunch meal in the main kitchen on [DATE] at 11:30 AM, the surveyor requested that the Food Service Director (FSD) take the temperatures of the foods on the tray located on the tray line. Further observation noted that the FSD did not properly sanitize the thermometer between foods and was noted to wipe the thermometer repeatedly with a soiled napkin. The surveyor requested that the FSD cease taking the food temperatures with a soiled napkin and requested that a alcohol wipe was required to sanitize the thermometer between foods. The FSD replied to the surveyor that the dietary department does not have a supply of alcohol wipes.</p> <p>3) [DATE] (7 AM Tour):</p> <p>* During the observation of the Breakfast meal in the main kitchen conducted on [DATE] at 7:30 AM, the surveyor requested that the that the temperatures of foods located on steam table be taken utilizing the facility's calibrated food thermometer by the Food Service Director. The temperature testing noted that hot foods were not being held at the minimum temperature 135 degrees F or above and cold foods were not being held at the minimum temperature of 41 degrees F or below as noted by the following:</p> <p>-Baked Eggs with Peppers & Onion = 116 degrees F</p> <p>-Orange Juice (Individual Portions) = 49 degrees F</p> <p>-Milk (Individual Portions) = 44 degrees F</p> <p>< The surveyor intervened to inform the Food Service Director that the foods should not be served until the regulatory required holding temperatures were achieved.</p> <p>4) ,d+[DATE] (11:30 AM Tour):</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>* During the observation of the lunch meal in the main kitchen conducted on [DATE] at 11:30 AM, the surveyor requested that the that the temperatures of foods located on steam table be taken utilizing the facility's calibrated food thermometer by the Food Service Director. The temperature testing noted that hot foods were not being held at the minimum temperature 135 degrees F or above and cold foods were not being held at the minimum temperature of 41 degrees F or below as noted by the following</p> <ul style="list-style-type: none"> -Mechanically Altered Ground Beef Brisket = 127 degrees F -Mechanically Altered Chopped Chicken Chicken Tenders = 1120 degrees F -Mechanically Altered Ground Chicken Tenders = 115 degrees F -California Blend Vegetables = 133 degrees F -Pureed California Blend vegetables = 127 degrees F -Apple Pie Sliced = 67 degrees F -Pureed Apple Pie = 78 degrees F <p>< The surveyor intervened to inform the Food Service Director that the foods should not be served until the regulatory required holding temperatures were achieved.</p> <p>5) [DATE] (11:30 AM Tour):</p> <p>* During the observation of the lunch meal in the main kitchen on [DATE] at 11:30 AM accompanied with the Corporate Dietary Manager, foods located on the steam tables and refrigerated foods were taken utilizing the facility's calibrated digital thermometer. The temperature testing noted that hot foods were not being kept at the regulatory temperatures of 135 degrees F or above and cold food were not being kept at the regulatory temperatures of 41 degrees F or below as evidenced by:</p> <ul style="list-style-type: none"> -Gefilte Fish Plates (2) = 52 degrees F -Diced Turkey Plate (2) = 51 degrees F -Sliced Turkey Plates (4) = 56 degrees F -Tuna Fish Plates (6) = 51 degrees F -Buttered Noodles (,d+[DATE] steam table pan) = 114 degrees F -Pureed Meat Balls (,d+[DATE] steam table pan) = 130 degrees F <p>< The surveyor intervened to inform the Food Service Director that the foods should not be served until the regulatory required holding temperatures were achieved.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>* Staff (C) - noted to temperature test steam table foods without properly sanitizing the thermometer stem between food. The surveyor was required to intervene to stop the potential threat of food contamination.</p>