STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105476	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Boca Raton Rehabilitation and Nursing Ce	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105476	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Boca Raton Rehabilitation and Nursing Ce	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedures, observation, record review and interview, the facility failed to ensure that a resident was treated in a dignified manner for 2 of 2 sampled residents observed with Foley Catheters, (Resident #31 and Resident #122). The findings included: Review of the un-dated facility policy titled, Dignity provided by the Director of Nursing (DON) documented in the Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation: 1. Residents are treated with dignity and respect at all times.12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered.1). Record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses which included Displaced Intertrochanteric Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Dementia, Neurogenic bladder and Obstructive Uropathy. She had a Brief Interview Mental Status (BIM) 5, indicating severe cognitive impairment. On 08/04/25 at 11:12 AM, Resident #31 was observed sitting up in her wheelchair in the Activity room adjacent to the North D-wing [NAME] Nurses' station, with her Foley catheter in place. It was noted that the blue privacy cover had not been adequately and completely covering her Foley catheter bag. The Foley catheter bag was visible half hanging out, and exposed to other residents, staff members and visitors. On 08/04/25 at 3:23 PM, Resident #31 was observed resting in bed in her room now with her Foley catheter in place on the side of her bed, visible from the doorway with the blue privacy cover still not adequately and completely covering the Foley catheter bag; it was still visible half hanging out, and exposed to other residents, staff members and visitors. On 07/16/25 the Physician's Order documented, . Provide privacy urinary drainage bag.On 08/05/25 at 3:49 PM, during a subsequent staff interview with Staff F, Certified Nursing Assistant, (CNA), she acknowledged that the resident's Foley catheter bag with a privacy cover was observed to be sitting on the floor and un-covered; when it should not have been, according to the CNA.On 08/05/25 at 4:07 PM, during interview with Staff G, Licensed Practical Nurse (LPN), she acknowledged that Resident #31's Foley catheter bag should not have been sitting directly on the floor; the nurse was not able to provide any explanation for this. Record review of Resident #31's Care plan initiated 07/15/25 indicated Focus: Resident has an Indwelling Catheter related to Neuromuscular Dysfunction, Obstructive Uropathy. Interventions: Position catheter bag and tubing away from entrance room door. Provide privacy urinary drainage bag.keep the urinary drain bag covered every shift. Goal: Resident will be/remain free from catheter-related trauma through review date, 2) Record review revealed Resident #122 was re-admitted to the facility on [DATE] with diagnoses which included Nontraumatic Intracerebral Hemorrhage, Intraventricular, Hemiplegia and Hemiparesis Following Nontraumatic Subarachnoid Hemorrhage Affecting Left Dominant Side and Neurogenic bladder. He had a Brief Interview Mental Status (BIM) 12, indicating moderate cognitive impairment. On 08/05/25 at 10:58 AM, Resident #122 was observed resting in his bed with his Foley catheter in place. It was noted that the blue privacy cover had not been adequately and completely covering his Foley catheter bag. The Foley catheter bag was visible from the door entry way and half hanging out, and exposed to other residents, staff members and visitors. On 5/6/2025 the Physician's Order documented, . keep the urinary drain bag covered. On 08/06/25 at 12:48 PM an interview was conducted with Staff H, CNA regarding Resident #122's Foley catheter bag, not being adequately and completely covered and exposed; she acknowledged that it should have been. On 08/06/25 at 11:29 AM an interview was conducted with Staff I, Registered Nurse (RN) regarding Resident #122's Foley catheter bag not being adequately and completely covered and exposed; she acknowledged that it should have been.On 08/06/25 at 12:23 PM during an interview conducted with Staff J, RN Unit Manager of the [NAME] unit, in which she also acknowledged that the resident's Foley catheter bag with privacy cover had only been partially covering the bag, leaving it exposed to other residents, staff members and visitors. And, Staff J, also acknowledged that Resident #31's Foley catheter bag should not have been sitting directly on the floor. Record review of Resident #122's Care plan initiated on 04/19/25 indicated Focus: has an indwelling foley catheter for retention related to Bladder Cancer and Irradiation Cystitis w/Hematuria, Neurogenic Bladder. Interventions: keep the urinary drain bag covered . Goal: Resident will be/remain free from catheter-related trauma through review date. Resident #31 and Resident #122's Foley catheter bags had not been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105476	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Boca Raton Rehabilitation and Nursing Ce	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105476	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Boca Raton Rehabilitation and Nursing Ce	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide assistance to a resident who was unable to carry out with Activities of Daily Living (ADLs) for 1 of 9 sampled residents (Resident #110) reviewed for ADLs.The findings included: Review of Resident #110's clinical record documents an admission to the facility on [DATE] with no readmissions. Resident's diagnoses included Cerebral Infarction with Non-Traumatic Intracerebral Hemorrhage, Encephalopathy, Urinary Tract Infection and Unsteadiness on Feet. Review of Resident #110's Minimum Data Set (MDS) Medicare 5 days assessment dated [DATE] documents that the resident needs substantial/maximal assistance with toileting hygiene, had frequent incontinence and was dependent on the staff for incontinence care. Resident BIMS (Brief Interview Mental Status) score was 3 of 15 indicating the resident has severe cognition impairment. Review of Resident #110's care plan initiated on 06/17/25 titled (resident's name.requires assist with activities of daily living. Interventions included .encourage resident to use the call bell system for assistance.skin inspection: monitor for redness, scratches.On 08/06/25 at 9:01 AM, observation revealed a beeping call device located by the nurse's station; the device indicated (read) 23 minutes and resident's room number (Resident #110). On 08/06/25 at 09:03 AM, an interview was conducted with Resident #110 who stated she kept calling because she was itching and wanted her brief change. Observation revealed the resident had her blouse up and was scratching around her waistline. Further observation revealed her skin around the waistline with redness. Resident #110's call light continued to be on.On 08/06/25 at 9:05 AM, observation revealed Staff D, Registered Nurse (RN) pushing her medication cart to the opposite side of Resident #110's room. Staff D did not acknowledge the call light and proceeded to pour medications.On 08/06/25 at 9:07 AM, observation revealed Staff Q, Certified Nursing Assistant (CNA) coming out of resident's room next to Resident #110 and did not acknowledge Resident #110's call light. On 08/07/25 at 9:09 AM, observation revealed Staff Q entered Resident #110's room and the resident's roommate Private Dut Aide Informed Staff Q that Resident #110 was itching and wanted her brief change before leaving to her appointment. At 9:10 AM, observation revealed Staff Q turned off the resident's call light and did not change the resident's brief. Staff Q came out of the room with full trash bags. On 08/06/25 at 9:16 AM, observation revealed Staff Q, CNA passing breakfast tray. Observation revealed 39 minutes had passed and Resident #110 request for brief change due to itching had not been completed.On 08/06/25 at 9:17 AM, observation revealed Staff D, RN, continues to be with the medication cart parked by the opposite side of Resident #110's room. On 08/06/25 at 9:19, an interview was conducted with Staff D, RN who stated Resident #110 was leaving for an outside appointment and she needed to give her medications. On 08/06/25 at 9:23 AM, a joint interview was conducted with Staff D, RN and Staff Q, CNA. They were apprised that Resident #110's call light was on for 23 minutes at 9:01 AM and was turned off at 9:09 AM, and the resident was complaining of itching related to her brief. Staff D stated she did not hear the call light sound, can't hear the call light sound in the hallway. Staff Q stated she did not know the light was on and that she was in another resident's room. Subsequently, a joint side by side observation of Resident #110's skin around her waistline was conducted with Staff D and Staff Q; they both confirmed resident's redness around the waistline, skin in contact with her brief. Staff D stated Yes, she is red.On 08/07/25 at 7:44 AM, an interview was conducted with Staff T, Licensed Practical Nurse (LPN) who stated she expects resident's call light response to be answered as soon as possible within 5 to 10 minutes. Staff T stated when the resident put the call light on, the resident's room showed up and pointed at a panel located at the nurse's station, Staff T stated she can hear the call light sound down the hall.On 08/07/25 at 7:47 AM, an interview was conducted with Staff R, Unit Manager who stated her expectations to answer a resident call light was about 5 to 15 minutes, she stated the staff can hear the call light sound down the hall, but it is hard when music is playing loud. On 08/07/25 at 8:38 AM, a joint interview was conducted with the Administrator and the Director of Nursing (DON). The administrator was asked of her expectations regarding the staff answering the residents' call light and stated it varies, they have to acknowledge it as soon as possible, the staff was educated to not turn it off until they fix the issue, added that if the staff are in another room, it may take 5 minutes. The administrator was apprised of Resident #110 call light device was on for over 30 minutes before the staff acknowledged, then it was turned off and the resident's request to have her brief change because it was itching and the skin was red was not done at the time the light was turned off. The administrator stated that 30 minutes is too long. The DON stated they had a set up that one CNA will check

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105476	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Boca Raton Rehabilitation and Nursing Ce	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105476	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Boca Raton Rehabilitation and Nursing Ce	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 1). Based on observations, interviews and record review, the facility failed to identify the need for skin care and treatment for 1 of 2 sampled residents reviewed for skin conditions (Resident #14); and 2). Based on observation, record review and interview, the facility failed to follow physician orders for 2 of 4 sampled residents observed during medication administration (Resident #137 and Resident #59). The findings included:1). Review of Resident #14's clinical records documented an admission date to the facility on [DATE] and a readmission on [DATE]. Resident diagnoses included Alzheimer's Disease, Trichotillomania, Dementia, Mood Disturbance, Anxiety, Cerebral Infarction and Speech and Language Deficits following other Cerebrovascular Disease.Review of Resident #14's care plan titled Skin.{resident's name} has a potential risk for skin breakdown due to picking at her skin.Diagnoses Alzheimer's and Trichotillomania. care plan was initiated on 12/19/2019. Interventions included: Assess skin during nursing care for s/s (signs and symptoms) of breakdown.Check body for s/s of bleeding.skin tears. Notify (Medical Doctor) of changes in skin integrity. Review of the nurse's notes dated 08/04/25, 08/05/25 and 08/06/25 documented .skin was also observed: skin is warm, skin is dry . The nurse's note did not address Resident #14's left eyebrow skin condition. On 08/04/25 at 10:45 AM, observation revealed Resident #14 in her room out of bed in a recliner wheelchair looking out the window. The surveyor attempted to interview the resident who was not able answer questions asked. Observation revealed the resident had an approximately one-inch-long laceration over her left eyebrow with dry blood noted. On 08/06/25 at 9:30 AM, an interview was conducted with Resident #14's Private Duty Aide (PDA) and inquired about the left eyebrow skin condition and stated the resident has a habit of picking a pimple on it, picks on the scab and if they put a band aid on, she pulls it off. Observation revealed the resident continued to have dry blood over her left eyebrow. On 08/07/25 at 1:58 PM, a side-by-side review of Resident #14's clinical record and the Minimum Data Set (MDS) assessment was conducted with Staff S, MDS Coordinator. Staff S stated the resident was dependent on the staff to complete her Activities of Daily Living including bathing and grooming. Resident #14's BIMS (Brief Interview Mental Status) score was 2 indicating the resident had severe cognition impairment. A side-by-side review of the resident's physician orders lacked evidence of a written order for the left eyebrow skin condition. On 08/07/25 at 2:24 PM, observation revealed Resident #14 continued to have the left eyebrow bleeding with no dressing and no physician orders for care. On 08/07/25 at 3:05 PM, a side-by-side review of Resident #14's August 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) and an interview was conducted with Staff A, LPN and Staff R, Unit Manager. Staff A was asked if there was a physician order for the resident's left eyebrow skin impairment and stated there was not an order for treatment to the left eyebrow. On 08/07/25 at 3:12 PM, observation revealed Resident #14 being wheeled down the hallway from the reception area by her PDA. Further observation revealed the resident had bleeding from the left eyebrow. Consequently, an interview was conducted with the resident's PDA who stated the resident is constantly picking on her eyebrow and she told the nurses to clean it, and their response was that the resident keeps doing it.On 08/07/25 at 3:14 PM, a side-by-side observation of Resident #14' s left eyebrow was conducted with Staff A, LPN and confirmed bleeding over the resident's left eyebrow. Further observation revealed the resident picking on her bloody left eyebrow area and then putting her fingers on her nose and her mouth. Staff A stated he will measure the opening and call the doctor for orders.On 08/07/25 at 3:50 PM, during an interview, the Director of Nursing (DON) was apprised of Resident #14's skin condition since the first day of survey on 08/04/25. The DON confirmed Resident #14's skin opening of 1.5 length and 0.5 cm width. 2). The facility's policy titled Administering Medications, published 01/27/2025, has a section with the subtitle of Policy Interpretation and Implementation. Under the subtitle for administering medications, item number 4 states: Medications are administered in accordance with prescriber orders, including any required time frame.2a). Record review revealed Resident #137 had a Brief Interview of Mental Status (BIMS) score of 15/15,Review of the physician's orders for Resident #137 revealed the following: Budesonide 0.5mg/2ml, 2 cc(ml) inhale orally via nebulizer every 12 hours for COPD (Chronic Obstructive Pulmonary Disease), rinse mouth after Tx (treatment).On 08/05/25 at 9:50 AM, Staff A, a Licensed Practical Nurse (LPN) was observed administering, Budesonide 0.5mg/2ml (the inhaled (via nebulizer) medication) for Resident #137. It was noted that Staff A did not instruct Resident #137 to rinse her mouth after the inhalation administration.On 08/05/2025 at between 11:00 AM and 11:30 AM an interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105476	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Boca Raton Rehabilitation and Nursing Ce	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105476	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Boca Raton Rehabilitation and Nursing Ce	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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedures, observation, record review and interview, the facility failed to ensure professional standards were followed for 1 of 1 sampled resident observed for Foley catheters (Resident #31). The findings included: Review of the un-dated facility policy titled Catheter Care Urinary provided by the Director of Nursing (DON) documented in the Policy Statement. The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections.General Guidelines.4. Ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site. Infection Control.2. Be sure the catheter tubing and drainage bag are kept off the floor. Maintaining Unobstructed Urine Flow: 1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. 1). Record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses which included Displaced Intertrochanteric Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Dementia, Neurogenic bladder and Obstructive Uropathy. She had a Brief Interview Mental Status (BIMS) score of 5, indicating severe cognitive impairment. During an observation conducted on 08/04/25 at 10:30 AM during an initial observational tour it was noted that the resident did not have a Foley catheter one-piece leg strap with an anchor in place, to secure the catheter for Resident #31. On 08/04/25 at 3:23 PM, Resident #31 was observed resting in bed with her Foley catheter in place. However, upon further observation, it was noted that the lower portion of her Foley catheter tubing was not observed to be properly positioned and was noted to have been wrapped and looped around the resident's right lower leg. On 08/05/25 at 3:49 PM during a subsequent observation of Resident #31 and a brief interview with Staff F, Certified Nurses' Assistant, (CNA), it was noted that there was still no Foley catheter one-piece leg strap with an anchor in place, to secure the catheter for the resident. Staff F said that the nurse would need to obtain the leg strap with the anchor this and put it on in place, for the resident. Furthermore, it was also noted, at that time, that Resident 31's Foley catheter bag, with privacy cover, was observed to be sitting on the floor and un-covered. On 07/30/25 the Physician's Order documented . Check that leg strap is in place. Observe for leakage and kinks. Check and ensure Foley securing device in place. Use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Rotate site of securement daily and as needed (PRN). On 08/05/25 at 4:07 PM, an interview was conducted with Staff G, Licensed Practical Nurse (LPN), in which she acknowledged that Resident #31's Foley catheter bag should not have been sitting on the floor, the resident's Foley catheter bag and tubing should not have been wrapped around the resident's leg, and Staff G also acknowledged that the Foley catheter one-piece leg strap should have been in place, as ordered. On 08/05/25 at 4:12 PM, an interview was conducted with Staff J, Registered Nurse (RN) Unit Manager of the [NAME] unit, in which she also acknowledged that the resident's Foley catheter bag tubing should not have been wrapped around the resident's leg, the Foley catheter bag should not have been sitting on the floor, and she also acknowledged that the Foley catheter one-piece leg strap should have been in place as ordered. 2) During a Foley and Peri-care observation, conducted on 08/06/25 at 10:18 AM for Resident #31, she was observed resting in bed and her care was performed by Staff K, CNA and Staff H, CNA, utilizing Procare wipes. It was observed that Resident #31's Foley catheter leg strap, with anchor, was placed too close to the Foley catheter base tubing and not properly positioned far enough away and down on the resident's right leg to allow an even flow of urine. There was a small kink noted in the upper portion of the Foley catheter tubing. Staff K acknowledged and revealed, a couple of times, during the procedure, that the Foley catheter leg strap with an anchor had not been positioned correctly and she stated that she was going to inform the resident's nurse to let her know to come and re-position it. Then, after finishing the Foley and Peri-care, Staff K gathered her used supplies and bags and she walked away, outside of the room, and down the hallway; Staff K failed to return to replace Resident #31's blue privacy Foley bag cover, allowing the resident's Foley catheter bag to be completely exposed and visible from the resident's front doorway entrance to other residents, staff members and visitors, for some time afterwards, until Surveyor intervention.On 08/06/25 at 11:25 AM, an interview was conducted with Staff L, LPN regarding the kinked Foley catheter tubing. She acknowledged that the Foley catheter leg strap and anchor should have been properly placed, in order to avoid any kinks in the Foley catheter tubing.Record review of Resident #31's Care plan initiated 07/15/25 indicated Focus: Resident has an Indwelling Catheter related to neuromuscular dysfunction, obstructive uropathy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105476	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Boca Raton Rehabilitation and Nursing Ce	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105476	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Boca Raton Rehabilitation and Nursing Ce	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the un-dated facility policy titled Oxygen Administration provided by the Director of Nursing (DON) documented in the Policy Statement.The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration.Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment. 5. The reason for p.r.n. (as needed) administration. 6. All assessment data obtained before, during, and after the procedure. 7. How the resident tolerated the procedure. Record review revealed Resident #196 was admitted to the facility on [DATE] with diagnoses which included Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Status Post (S/P) Aortic Valve Replacement (AVR), S/P Coronary Artery Bypass Graft (CABG) x2, Cardiomegaly and Pleural Effusion. He had a Brief Interview Mental Status (BIMS) score of 15, indicating intact cognition. On 08/04/25 at 12:55 PM, Resident #196 was observed with Oxygen infusing at two (2) liters via nasal cannula from a wall unit; with no specific parameters for the continuing and on-going administration of the Oxygen for the resident (e.g. frequency, rate of Oxygen flow and maintenance of Oxygen saturation level). On 08/04/25 at 4:13 PM Resident #196 was observed with Oxygen infusing at two (2) liters via nasal cannula from a wall unit. But, still with no current active Oxygen orders noted on record; with no specific parameters for the continuing and on-going administration of the Oxygen for the resident e.g. frequency, rate of Oxygen flow and maintenance of Oxygen saturation level. A brief interview was conducted with Resident #196 on 08/04/2025 at 4:23 PM in which he stated that he had recently had heart surgery, and he had been receiving the Oxygen continuous at two (2) liters, since his admission to this facility. On 08/05/25 at 11:16 AM Resident #196 was observed with Oxygen infusing at two (2) liters via nasal cannula from a wall unit. But, still with no current active Oxygen orders noted on record; with no specific parameters for the continuing and on-going administration of the Oxygen for the resident (e. g. frequency, rate of Oxygen flow and maintenance of Oxygen saturation level. On 08/05/25 at 3:52 PM Resident #196 was observed with Oxygen infusing at two (2) liters via nasal cannula from a wall unit. But, still with no current active Oxygen orders noted on record; with no specific parameters for the continuing and on-going administration of the Oxygen for the resident (e.g. frequency, rate of Oxygen flow and maintenance of Oxygen saturation level).Record review revealed there was a previous notation in the Hospital physician's Interventional Cardiology Progress notes dated 07/21/25 and 07/23/25 (under Hospital clinical notes) for Oxygen administration of two (2) liters via nasal cannula for an Oxygen saturation rate of 96%, at the time, for the resident. On 07/25/25 the Respiratory Therapy (RT) Clarification order by Staff M, RT documented: Skilled Treatment. for x 7 days/week x 30 days. Treatment may include: aerosol treatment, deep breathing/coughing, Forced Expiratory Time (FET), Bronchial Hygiene treatment, Lung Expansion treatment, Assessing, Monitoring, Patient education, Oxygen weaning, High-Flow Nasal Cannula (HFNC) monitoring, Positive Expiratory Pressure (PEP) and Oscillating Positive Expiratory Pressure Therapy (OPEP), Spirometry Testing, Airway Clearance Technique, Omni-flow, Inspiratory Muscle Training (IMT) and Expiratory Muscle Training (EMT), Active Cycle of Breathing Techniques (ACBT), Hyperinflation Therapy and Cardiopulmonary exercises. Record review of the Resident #196's Shortness of Breath (SOB) Care plan initiated on 07/24/25 indicated Focus: Resident has potential for Shortness of Breath related to cough, wheezing. Interventions. Administer medications per physician order . Goal: will have no complications related to SOB though the review date. Record review of the Resident #196's Care plan initiated 07/24/25 indicated Focus: has an Alteration in Cardiovascular Function related to coronary artery bypass grafting x2, AVR, left atrial clip, severe multivessel coronary artery disease, Coronary Artery Disease (CAD) with previous PCI, severe aortic insufficiently. Other Diagnosis: Hyperlipidemia (HLD), Atrial Fibrillation. Interventions. Administer meds as prescribed Nursing, Assess 02 needs and provide as ordered by MD. Nursing .Goal: Resident will maintain current cardiac output as evidenced by no or decreased edema, SOB or other related symptoms by review date. Record review of Resident #196's Oxygen saturation rates between the dates of: Thursday 07/24/25 at 16:00 PM and Monday 08/4/25 at 20:32 PM, revealed that resident's Oxygen saturation levels range was from 91.0% @ 2 L/Min Oxygen via Nasal Cannula up to 97. 0% Oxygen via Nasal Cannula. Further record review of the facility's admitting nurses' progress note dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105476	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Boca Raton Rehabilitation and Nursing Ce	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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105476	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Boca Raton Rehabilitation and Nursing Ce	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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow doctors' orders for 2 of 4 sampled residents during the Medication Administration Observation. (Resident #59, Resident #137). There were 2 errors for 27 opportunities which resulted in an error rate of 7.41%.The findings included: The facility's policy titled Administering Medications, published 01/27/2025, has a section with the subtitle of Policy Interpretation and Implementation. Under the subtitle there is a numbered list that describes the policy and the procedure for administering medications. Item number 4 states Medications are administered in accordance with prescriber orders, including any required time frame. On 08/05/25 at 9:50 AM, a Medication Administration observation was conducted with Staff A, a Licensed Practical Nurse (LPN). The medication administration was performed for Resident #137 who resided in room [ROOM NUMBER]-W on the B-Wing. Resident #137 had a Brief Interview of Mental Status (BIMS) score of 15/15, which indicates the resident was cognitively intact. The medications administered to Resident #137 included the following medications:Budesonide 0.5mg/2ml - an inhaled (via nebulizer) medication. Arformoterol Tartrate 15mcg/2ml - an inhaled (via nebulizer) medication Albuterol Sulfate 2.5 mg / 3 ml - an inhaled (via nebulizer) medicationMedications #1 and # 2 were administered together via nebulizer. According to the Medscape.com Drug Interaction Guide and the Drugs.com Interaction Checker the combination of these two medications is considered safe.The order for Medication #1 is as follows:Budesonide 0.5mg/2ml, 2 cc(ml) inhale orally via nebulizer every 12 hours for COPD (Chronic Obstructive Pulmonary Disease), rinse mouth after Tx (treatment).Staff A administered Medications #1 and # 2 together before administering Medication #3. Staff A did not instruct Resident #137 to rinse her mouth after the combined inhalation administration, which included instructions to do so. Resident #137 was not instructed to rinse her mouth after any inhalation treatment. The inhaled treatments were performed after other medications were administered.On 08/05/2025 at between 11:00 AM and 11:30 AM an interview was conducted with the Director of Nursing (DON) to inform her of the error. The DON reviewed the doctor's orders and verified that the medication Budesonide had an order that clearly stated to have the resident rinse her mouth after the treatment.On 08/06/25 at 9:06 AM, a Medication Administration observation was made of Staff B, an LPN, for Resident #59 who resided in room [ROOM NUMBER]-D on the C-Wing. Resident #59 had a BIMS of 14/15, which is considered cognitively intact. Resident #59 had the following medication order:Sodium Zirconium Cyclosilicate Oral Packet 5 GM (Sodium Zirconium Cyclosilicate) Give 1 packet by mouth one time a day every other day for hyperkalemia mix with 8oz of H2O. Staff B was observed mixing the medication in a small plastic cup. The medication was completely dissolved and administered to Resident #59On 08/06/25 at 1:00PM, the surveyor noted that the plastic cup appeared small. A second cup was removed from the nurses medication cart along with a medicine cup. The medicine cup holds 30 ml of liquid which is equivalent to 1 ounce (oz). The surveyor filled the medicine cup 4 times and filled the drinking cup.On 08/06/25 at 1:15 PM, an interview was conducted with Staff C, an LPN on the C-Wing, who stated the cups on the carts were 5-ounce cups. Staff C showed the surveyor that on the bottom of the cup was embossed with 5 oz. It was noted by the surveyor that not all cups had the ounces on the bottom of the cup. Staff C stated that those were the only cups they had. Staff C stated that the facility used to supply 8 oz cups, but they ran out. Staff C stated they expected to have the larger cups again soon. On 08/06/25 at 1:20 PM, an interview was conducted with Staff D, an LPN on the B-Wing. Staff D confirmed that the facility only had small cups for the medication carts.On 08/06/25 at 1:38 PM, an interview was conducted with Staff E, the Central Supply clerk. Staff E explained that the facility ran out of 8-ounce cups, and she had been supplying the 5-ounce cups instead. Staff F stated that the 8-ounce cups had recently been received but had not distributed to the nurses' carts yet. When asked about other types of cups, Staff E stated the kitchen has larger cups. When asked why she did not order 8-ounce cups like those supplied to the kitchen Staff E stated she had not thought of it. On 08/06/25 at 2:12 PM, an interview was conducted with the DON regarding the medication error. The DON was aware that the medication carts were only supplied with small 4 to 5 ounce cups. The DON agreed that the nurses need to follow the doctors' orders regarding medications dissolved in liquids. The DON verified the doctor's orders and determined the surveyor was correct, the order stated to mix with 8 ounces of water. The DON was surprised that the Staff F did not think to order 8 ounce hot cups, like those the kitchen used.