STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105485	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamlin Place of Boynton Beach	2180 Hypoluxo Road Lantana, FL 33462

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31746 Based on record review and interview, it was determined that the facility failed to inform 1 of 1 sampled resident (Resident #28) of her rights to receive timely specialized rehabilitation services, physical therapy (PT) and occupational therapy (OT). The finding included: Review of the facility's policy titled, Scheduling Therapy Services revised July 2013 documented, Therapy Services shall be scheduled in accordance with the resident's treatment plan; and Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. Resident #28 was admitted to the facility on [DATE]. Her admitting diagnoses included: Unspecified Atrial Fibrillation; Atherosclerotic Heart Disease Of Native Coronary Artery. Difficulty In Walking; Pain; Dislocation Of Right Shoulder Joint; Non-displaced Intertrochanter Fracture Right Femur; Low Back Pain; Pain In Right Shoulder; Muscle Wasting And Atrophy; Pain In Left Knee; Chronic Obstructive Pulmonary Disease; Pain In Right Hip; History Of Falling; Primary Osteoarthritis, Right Shoulder. Resident #28 required immediate therapeutic interventions as ordered by her physician. Review of the Physicians' Orders dated 05/17/2024 revealed a physical therapy (PT) and occupational therapy (OT) orders to evaluate and to treat Resident #28. The PT and OT clarification orders dated 06/3/2024 indicated the following: OT treatment 3 x week x 60 days for self-care, wheelchair management, group treatment, manual therapy, and a PT clarification order for PT treatment 3x/week x60 days for therapeutic-exercises, therapeutic activities, gait training, and safety education. In essence, Resident #28 was supposed to receive both physical and occupational therapies three times a week for 60 days. Review of the plan of care dated 05/17/2024, for PT and OT documented Resident #28 had: Alteration in musculoskeletal status related to post fall with diagnosis of right hip nondisplaced fracture. The plan outlined the following objectives: Resident #28 will return to prior level of function after rehabilitation. Resident #28 will return to prior level of function with activities of daily living after rehabilitation, etc. (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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, the Director of Nursing (DON) stated on 06/13/24 at 9:12 AM that Resident #28 would remain at the facility long-term. The DON also revealed that therapy assessment usually is done within 24-hours of a resident's admission to the facility. Therapy services usually begin between 24-72 hours of the resident's admission. The DON also stated that it is the facility's policy for ensuring that therapeutic services are provided timely. Interviews with the Lead Physical Therapist (Employee A) and the Physical Therapy Consultant on 06/13/24 at 09:16 AM, revealed that the facility has 24-to 48 hours to assess residents' physical needs, or conduct an evaluation for all newly admitted residents. However, therapeutic treatment did not start for Resident #28 until 06/3/2024 for both Physical Therapy and Occupational Therapy. The Rehabilitation Consultant explained that physical therapy services were delayed because of a payor source issue. She added that the Physician Order to evaluate and treat Resident #28 was issued on 05/17/2024, but they were not sure who was going to pay. Also, Resident #28 had a private insurance that had denied the authorization to treat, or to pay for services. The Rehabilitation Consultant further stated that delaying provision of services was an error of their part. They were obliged to evaluate and treat Resident #28, as per physician's orders. During an interview on 06/13/24 at 9:39 AM, the Business Office Manager (BOM) stated before admitting any resident to the facility, the Admission Coordinator usually shares with the business office information regarding the incoming resident payor source, whether it is Medicare part A or B, Medicaid or private insurance. The BOM stated once a resident is admitted to the facility, services must be provided. The BOM added there should not be any reason to delay treatment once the physician has given the order to assess and treat the resident. The BOM explained that Resident #28 had a Medicaid case pending but she was eligible for Medicare Part B since her admission to the facility, and was eligible for rehabilitation services. The BOM said that the Rehabilitation Department was supposed to bring the physician order to the business office to initiate the process or authorization for treatment, but they did not bring anything to her. During an interview on 6/13/24 at 9:45 AM, the Admission Director (AD) stated that she knew that Resident #28 had [ ] insurance prior to her being admitted to the facility. The facility that the resident was admitted from told her that the resident would no longer receive services from [.]. The AD stated that they made it clear to Resident #28's legal representative and the family that [ ] would not approve services since Resident #28 had reached her highest physical level from the facility she was being discharge from. The AD stated because of that reason PT and OT treatment was delayed until 06/3/2024. They were waiting for Resident #28 to be disenrolled from the [ ] plan and to enroll in the Medicare part B plan. During an interview on 06/13/24 at 10:41 AM, Resident #28 stated that she was admitted to the facility on [DATE]. She said that when she arrived at the facility, they told her that she had to wait to have therapy. She said that she did not know that she could have been treated within 24-hours of her admission, while her case was being processed. She stated that since she started treatment she has made significant progress, she is now able to stand. However, Resident #28 said that it was brutal laying in bed for three weeks while waiting for approval of her Medicare benefits. She wished someone had explained this to her sooner. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The findings were discussed with the Administration at the exit conference on 06/13/2024 at 3:49 PM, and the representatives were offered an opportunity to provide any further information regarding the identified concern. There were no questions. The Administrator acknowledged the findings.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31746 Based on interview and record review, the facility failed to provide accommodations to 1 of 1 sampled resident (Resident #28) to attend her care plan meeting, The findings included: Resident #28 was admitted to the facility on [DATE]. Her admitting diagnoses included: Unspecified Atrial Fibrillation; Atherosclerotic Heart Disease Of Native Coronary Artery. Difficulty In Walking; Pain; Dislocation Of Right Shoulder Joint; Non-displaced Intertrochanter Fracture Right Femur; Low Back Pain; Pain In Right Shoulder; Muscle Wasting And Atrophy; Pain In Left Knee; Chronic Obstructive Pulmonary Disease; Pain In Right Hip; History Of Falling; and Primary Osteoarthritis, Right Shoulder. Review of the Minimum Data Set (MDS) assessment dated [DATE], section titled Brief Interview of Mental Status recorded Resident #28 had a score of 14 out of 15 on the assessment. This score identified Resident #28 as being cognitively, mentally sound to handle her personal affairs. In addition, the Face Sheet documented Resident #28 is her sole responsible party. During an interview conducted on 06/13/24 at 11:08 AM, the MDS Coordinator stated that she had invited Resident #28 to attend the Care plan meeting held on 05/28/2024, but the resident did not want to get out of bed. The MDS Coordinator stated that she did not offer to have the meeting in the resident's room. Instead, the MDS Coordinator stated that she contacted Resident #28's son, who is identified on record as emergency contact #1, and the resident's daughter is listed as the resident's Power of Attorney (POA) and financial emergency contact #2. Review of the Social Services notes documented, in part: Call placed to Son . and he connected with his sister . for care plan meeting for Resident #28. Team reviewed resident's medication, diagnosis, discharge planning, and answered questions. Review of the Care Plan notes dated 05/28/2024 revealed that the meeting was held without Resident #28 being present. All decisions and plans were made and discussed with and by the interdisciplinary team (IDT), Resident #28's children, and her son-in-law, via phone conference. During that meeting, the team discussed Resident #28's Medications; Resident #28's family wanted resident to continue with taking the pain meds more often, and the facility suggested that the Tramadol be changed to routinely rather than as needed (prn) and everyone agreed. The Pain management Doctor was notified of the family's request. The Family wanted Resident #28 to be out of bed (OOB) for at least 90 mins or as she can tolerates sitting up. The MDS Coordinator documented that she spoke with the resident, who stated the most she can sit upright is no more than 90 minutes because she has spinal stenosis and Arthritic pain. In all, the decisions were made on behalf of Resident #28 while Resident #28 was not given the opportunity to attend the meeting. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Social Worker (SW) on 06/13/24 at 11:21 AM revealed that he was present during the care plan (CP) meeting. The SW said that the CP was held in the conference room; the resident was not present, and he did not know why. The SW said that the facility should have invited Resident #28 to the meeting. The findings were discussed with the Administration at the exit conference on 06/13/2024 at 3:49 PM, and the representatives were offered an opportunity to provide any further information regarding the identified concern. There were no questions. The Administrator acknowledged the findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31746 36734 Based on observation, interview, and record review, the facility failed to ensure proper care and services for a rash for 1 of 1 sampled resident reviewed for skin issues (Resident #67). The findings included: Record review revealed Resident #67 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had mild cognitive impairment and required substantial/maximal assist with activities of daily living. Resident #67 was care planned on 04/30/24 for a skin rash with an intervention to administer medication as ordered. An interview was conducted with Resident #67 on 06/10/24 at 12:30 PM. The resident complained of an itchy rash all over her body. The resident was observed with red raised bumps on her left leg, right stump, abdomen, chest, arms, and face. The resident stated she also had the rash on her back and buttocks. Resident #67 stated the facility had given her a cream, but it does not help. The resident stated she asked to see a dermatologist, but has not heard anything yet. Record review revealed Resident #67 had an order dated 05/30/24 for a dermatologist consult for a body rash. Further review of the resident's orders revealed an order dated 06/10/24 for Triamcinolone Acetonide External Cream (medication is used to treat a variety of skin conditions such as eczema, dermatitis, allergies, rash) to apply to face, arms, back topically every shift for rash for 15 days. Further record review revealed an order dated 06/11/24 for Ivermectin (an antiparasitic) one time for Dermatitis for 1 day. An interview was conducted with the Assistant Director of Nursing (ADON) on 06/11/24 at 12:30 PM. The ADON stated Resident #67 did not have scabies, but has had a rash for some time. The ADON stated they used to have a Dermatologist to see residents in the facility, but not anymore. They were in search for a Dermatologist. A second interview was conducted with the ADON on 06/11/24 at 1:00 PM. The ADON stated the earliest appointment they were able to get Resident #67 was on 06/21/24. Class III