STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105496	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Isles of Boynton Nursing and Rehab Center	3001 South Congress Avenue Boynton Beach, FL 33426

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observations interviews and record review the facility failed to ensure correct medications were given as per physician's orders for 1 out of 25 opportunities for medication administration affecting Resident #155. The findings included: Review of the facility's policy titled, Clinical-Medication Administration with a revised date of 12/10/25 included in part the following: Guidelines for Medication Administration: Have a working knowledge of the medication you are administering; common dosage, common uses, common side effects, and reason the medication is being given to the resident. Use available resources such as drug handbooks, medication package inserts, medication websites, the provider, or the pharmacist if unfamiliar with the medication. Observe the Rights of Medication Administration: Right Medicine. Record review for Resident #155 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Displaced Avulsion Fracture (Chip Fracture) of Left Talus, Pressure Ulcer of Other Site, Acute Kidney Failure, and Type 2 Diabetes Mellitus. The Minimum Data Set assessment dated [DATE] documented in Section C a Brief Interview of Mental Status score of 15, indicating a cognitive response. Review of the Physician's Orders for Resident #155 revealed in part the following:An order dated 12/22/25 for Ascorbic Acid tablet 500mg give 1 tablet by mouth one time a day for wound healing. There was no order for Saccharomyces Boulardii 500mg for the resident. On 02/10/26 at 9:07 AM, an observation of a medication pass was conducted with Staff H, a Licensed Practical Nurse (LPN), for Resident #155. The nurse prepared Saccharomyces Boulardii 500mg and entered Resident #155's room to administer it. However, the wrong medication was not given to the resident, as the surveyor intervened and prevented the nurse from proceeding. During an interview conducted on 02/10/26 at 9:10 AM with Staff H LPN who was asked about the order for Resident #155 for the ascorbic acid 500mg. The LPN said she thought it was the same as the Probiotic Saccharomyces Boulardii 500mg. When asked what is the other name for ascorbic acid, she looked it up and said it is Vitamin C and acknowledged it was not the same medication.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure resident received wound care in a manner consistent with professional standards of practice to promote the healing of pressure ulcers for 1 of 1 sampled resident observed for wound care (Resident #21). The findings included:Review of the facility's policy titled, Dressing -Dry/Clean with an effective date of 04/01/22 included in part the following: Perform hand hygiene, put on clean gloves, Use no-touch technique. Use sterile tongue blades (depressor) and applicators to remove ointment and creams from containers. Apply the ordered dressing and secure with tape or bordered dressing per order. Record review for Resident #21 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Quadriplegia, Chronic Osteomyelitis Left Thigh, Pressure Ulcer of Unspecified Site, Severe Protein Calorie Malnutrition, and Major Depressive Disorder. The Minimum Data Set assessment dated [DATE] documented in Section C a Brief Interview of Mental Status score of 12, indicating moderate cognitive impairment. Review of the Physician's Orders for Resident #21 revealed in part the following:An order dated 02/06/26 for wound care to sacrum: Cleanse with Dakin's solution 1/4 strength. Pat dry. Skin prep peri wound. Apply hydrogel or SilvaSorb and saturated gauze dressing or kerlix to wound bed. Cover with silicone foam dressing daily and as needed.An order dated 02/06/26 for wound care to right ischial: Cleanse with Dakin's 1/4 strength solution. Pat dry. Skin prep peri wound. Apply hydrogel or SilvaSorb and saturated gauze dressing or kerlix to wound bed. Cover with silicone foam dressing daily and as needed every night shift and every 8 hours as neededAn order dated 02/06/26 for wound care to left ischial: Cleanse with Dakin's 1/4 strength solution. Pat dry. Skin prep peri wound. Apply hydrogel or SilvaSorb and saturated gauze dressing or kerlix to wound bed. Cover with silicone foam dressing daily and as needed every night shift for Wound Healing and every 8 hours as neededAn order dated 02/11/26 for Silver External Gel (Silver) Apply to Sacrum topically every night shift for wound healing and every 8 hours as needed for wound healing. On 02/11/26 at 9:30 AM, an observation of wound care for Resident #21 performed by Staff A Wound Care Registered Nurse (WCRN) Wound Care who stated he has worked at the facility since March 2025; he was assisted by Staff B, Certified Nursing Assistant. Both staff performed hand hygiene. The WCRN gathered supplies. Both staff washed hands and applied a gown and gloves. The WCRN had placed the gown with thumb opening over the gloved hands. The resident was turned to his right side, the WCRN removed the old dressing [it was one dressing covering the sacrum (a triangular bone in the lower back situated between the two hipbones of the pelvis) and both left and right ischium (hip bones)]. He took his thumb out of the opening of the gown, removed his gloves, performed hand hygiene, applied gloves, and left the sleeves of the gown over the gloves without placing his thumb in the opening of the sleeve of the gown. The WCRN proceeded to use gauze pads soaked in Dakin's solution quarter strength and placed the gauze over the 3 wounds (sacrum, left and right ischium) as well as surrounding skin to the three wounds, then proceed to remove the Dakin's soaked gauze pads and use additional Dakin's soaked gauze pads to clean the wound beds (all 3 wounds) as well as the surrounding skin. The left ischium wound had some blackened area in the wound bed and macerated (white) wound edges, the right ischium wound had macerated (white wound edges), and the sacral wound had macerated (white) wound edges, the skin below the sacral wound between the ischium wounds was a dark greyish-black color. The WCRN then used dry gauze to pat dry all three wounds and the surrounding skin to the wounds. The WCRN removed his gloves, used hand sanitizer, pulled back the privacy curtain to open with his right hand to obtain another set of gloves, then pulled the privacy curtain closed with his ungloved right hand and put the gloves on. The WCRN then took a tongue depressor and removed some of the Silver gel from the med cup it had been placed in and proceeded to put the silver gel on each of the three wounds and some of the surrounding skin with the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	same tongue depressor and repeatedly dipping it in the same silver gel in the med cup. During the process of applying the silver gel, the WCRN's sleeve of the gown was close to the wound bed and the CNA moved his sleeve up his arm for the WCRN (it was unclear if the sleeve of the gown touched the wound). The WCRN then applied skin prep to the outer edge of each wound using a separate skin prep pad for each wound. The WCRN then took rolled gauze and cut a long strip about 24-36 inches long and soaked it in the Dakin's solution, wrung it dry and then placed the one long piece of Dakin's soaked gauze over the right ischium wound, across healthy skin, onto the sacral wound, continuing across more healthy skin, on to the left ischium wound and back to the sacral wound and onto the right ischium wound. The WCRN then used two large, bordered dressings to cover the 3 wounds, however the gauze between the sacrum and the right ischium was not completely covered. When this was brought to the attention of the WCRN, he said he could reinforce it with another bordered dressing. The WCRN then stated, It is because of the position, we just cannot.(and trailed off his words). During the entire process the resident remained on his right side except when the CNA lifted the resident's buttocks up off the bed for the WCRN to place the dressing on the resident's right ischium to reinforce the dressing after the surveyor had intervened. During an interview conducted on 02/11/26 at 10:35 AM with Staff A WCRN, who stated he Felt very confident in what he is doing. When asked about the sacral and ischium wounds for the resident if they were improving, getting worse or staying the same, he said they are staying the same for now. During an interview conducted on 02/12/26 at 7:45 AM with Wound Care Nurse Practitioner WCNP who was asked about 3 wounds for Resident #21, specifically the sacral, left and right ischium wounds, The WCNP stated those particular wounds have improved overall in the past couple of months, and he has debrided the wounds in that time as well. When asked about the wound care orders, he said he does not put them into the facility's system directly, it is in his system and then the orders are put into the facility's system by the (presumably) the wound care nurse. When asked about the order that says hydrogel or SilvaSorb (silver gel), he said he prefers them to use the hydrogel but may substitute with the silver gel. The facility sometimes has difficulty getting hydrogel from pharmacy due to insurance or some other reason so he is okay with either of the medications to be used but would prefer the hydrogel. When asked if the peri wound should be cleaned with the Dakin's solution, he said no, it may compromise the healthy skin surrounding the skin. When asked if the SilvaSorb should be placed in each wound using the same tongue depressor, he said no, that could possibly cross-contaminate the wounds. When asked about placing the SilvaSorb gel on the peri wound (outside edge of the wound), he said no, it is only to be placed on the wound bed, it may damage the heathy tissue. When asked about placing a one piece of Dakin's soaked kerlix gauze across all three wounds and some of the surrounding healthy tissue in between the wounds, he said absolutely not, it would destroy the healthy tissue between the wounds, and it should be placed only in the wound bed of each individualized wound. When asked if the wound and all gauze used would need to be covered, he said yes, due to the resident having issues with incontinence of stool despite having a colostomy. During an interview conducted on 02/12/26 at 2:30 PM with Staff A WCRN who was asked about the wound care he provided for Resident #21, he said he realized after speaking with the Wound Care Nurse Practitioner that he could improve in some areas with the wound care he provides. In summary Staff A WCRN put gloves without performing hand hygiene after touching the privacy curtain twice with his hand, reused the one tongue depressor multiple times for all three wounds, did not perform wound care with good technique putting healthy skin at risk for breakdown, and did not perform wound care as per physician's orders.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure securing a device in place for 1 of 6 sampled residents with an indwelling catheter (Resident #21). The findings included:Review of the facility's policy titled, Nursing - Physician's Orders with a revised date of 03/10/23 that included in part the following: Treatment orders: all treatments should include the treatment to be used and location of where the treatment should be placed, frequency and if appropriate, how the area should be cleaned and how it should be covered. Reason for the treatment required (diagnosis). Record review for Resident #21 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Quadriplegia, Chronic Osteomyelitis Left Thigh, Pressure Ulcer of Unspecified Site, Severe Protein Calorie Malnutrition, and Major Depressive Disorder. The Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status score of 12 indicating moderate cognitive impairment. Record review revealed an order dated 02/05/26 to include Urinary Catheter: Change Catheter Anchor/Securement Devices as needed Encourage and assist resident to use/apply securing device to catheter as tolerated. May replace and change location as needed. On 02/11/26 at 9:30 AM an observation of wound care was conducted for Resident #21 performed by Staff A, Wound Care Registered Nurse (WCRN), who was assisted by Staff B, Certified Nursing Assistant (CNA). It was also observed during the wound care that Resident #21 had an indwelling urinary catheter that was not anchored. When the WCRN and CNA were finished with the wound care, the CNA removed the adhesive from the anchor that was on the indwelling catheter tubing and secured the indwelling urinary catheter to the resident's upper right thigh. During an interview conducted on 02/11/26 at 10:40 AM with Staff B, CNA ,who was asked about the securing device for the urinary catheter, she said she noticed it was no attached to the resident, so she removed the backing and adhered the anchor to the resident's leg to secure the tubing.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain Intravenous (IV) access dressing in a sanitary manner and failed to change an IV access dressing as per facility policy for 1 of 1 sampled resident reviewed for IV access, (Resident #194). The findings included: Review of the facility policy titled Policy and Procedure: Clinical-Medication Administration revised 12/05/2025 documented Purpose: To administer medications as per provider's order and in accordance with regulatory guidelines and practice standards. Intravenous Medication or Fluids (IV therapy): . complete dressing changes as ordered and as needed to the insertion site. Review of the record revealed Resident #194 was admitted to the facility 01/20/26 with a diagnosis of Heart Failure. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #194 had a Brief Interview for Mental Status (BIMS) score of 13, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of Resident #194's orders revealed the following: Insert peripheral/midline for IVF bolus give hypotension and persistent AKI. One time only for AKI for 7 Days. (Completed order; Order Date/Time 1/29/2026 11:30 AM; End Date 2/05/2026) D/C MIDLINE one time only for d/c midline until 02/10/2026 23:59(Completed order; Order Date/Time 2/10/2026 10:45 AM) There were no orders for IV dressing changes or monitoring/assessment of IV. Review of the care plans did not reveal any IV/Midline care plans since admission date. An observation and interview was conducted with Resident #194 on 02/09/26 at 10:43 AM and a right upper arm Midline was observed. The dressing appeared dirty with dried dark red blood underneath the dressing. The resident was asked if the surveyor could take a picture of the dressing and the Resident agreed. The dressing was dated 01/29 which was 11 days prior. The resident was asked if she was still receiving anything through her IV, Resident #94 stated her medications had been completed since last week and the nurses had told her they cannot remove it without the doctor's order. When asked if anyone had changed her dressing since inserting it, Resident #194 stated no one had changed it. Resident #194 stated, It hurts and it is pinching my skin. During an interview on 02/10/26 at 12:00 PM, Resident #194 stated her IV was taken out by her nurse today and stated her arm felt better now that it was out. During an interview on 02/11/26 at 1:35 PM when asked how often do you perform an IV assessment and what do you look for, Staff C, Licensed Practical Nurse (LPN) stated it was performed every shift and that she looked for swelling, redness, signs of infection, and that it flushed well. When asked if she expected to see a dressing change order with an insertion of an IV, Staff C stated yes she would expect to see it. When asked how often dressing changes on IVs were performed, Staff C stated every 7 days and as needed. When asked how she knew that, Staff C stated it would be part of the dressing change order. Staff C was shown a picture of Resident #194's IV and asked what she saw in the pictures, Staff C gasped when she saw the pictures and stated oh wow, its bloody, dirty and needs to be changed. During an interview on 02/12/26 at 10:18 AM when asked how often do you perform an IV assessment Staff D, Registered Nurse (RN) stated every shift. When asked if she expected to see a dressing change order with an insertion of an IV, Staff D stated yes she would expect to see it. When asked how often dressing changes on IVs were performed, Staff D stated weekly and as needed. Staff D was shown a picture of Resident #194's IV and asked what she saw in the pictures, Staff D stated the dressing needed to be changed and looked yucky. During an interview on 02/12/26 at 10:30 AM when asked how often do you perform an IV assessment and what do you look for Staff E, LPN, stated every shift and she looked that it was clean, not infiltrated, could flush, signs of infection, and that the line was in place. When asked if she expected to see a dressing change order with an insertion of an IV, Staff E stated yes she would expect to see it and stated normally night shift did it. When asked how often dressing changes on IVs were performed, Staff E stated weekly and as needed. When asked if Staff E expected a care plan to be in place for a Resident with an IV, Staff E stated of course they have to have a care plan. Staff E was shown a picture of (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #194's IV and asked what she saw in the pictures, Staff E stated that it was past 7 days and needed to be changed, and stated it was crusty and bloody. During an infection control interview on 02/12/26 at 11:09 AM, when asked how often nurses perform IV assessments, the Assistant Director of Nursing (ADON) RN stated every shift. When asked if she expected to see an order for a dressing change, she stated yes and that they were done every 7 days and as needed. The ADON stated they should be making sure the dressing is intact with no signs of infection. The ADON was shown a picture of Resident #194's IV and she stated there was blood on the dressing and acknowledged it was 11 days old and needed to be changed. The ADON was made aware this IV was not removed until 02/10/26 (12 days after insertion), the order stated it was to stay in for 7 days, no IV monitoring/assessment orders were in place, no IV dressing change orders were in place, and no care plan was found. She agreed with the findings and stated she will provide additional education to the nurses. During an interview on 02/12/26 at 12:35 PM, when asked how often nurses are expected to perform an IV assessments, the Director of Nursing (DON) stated she had to double check her policy. When asked how often IV dressing were changed she stated that per facility policy PICC (Peripherally Inserted Central Catheter) and Midlines it were every 7 days and as needed. When asked if she would expect to see a dressing change order with an IV insertion, she stated yes. The DON stated the ADON had already made here aware about these concerns. The DON was shown the picture of Resident #194's IV and agreed with the findings and stated she would provide more education to the nurses. The DON was also made aware there was no care plan for this midline and stated she would look for it. During a follow up interview on 02/12/26 at 2:35 PM the DON stated she agreed that there was no care plan for Resident #194's midline and should have had one.

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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** Based on observation, interview and record review the facility failed to provide respiratory care in a manner consistent with physician orders and facility policy for 1 of 1 sampled resident reviewed for tracheostomy care (Residents #223.) The findings included: Review of the facility's policy titled Policy: Nursing- Tracheostomy Care dated 04/01/22 documented .Equipment and Supplies 1.Gloves (clean and Sterile) 2.Mask and eyewear (as indicated).Procedure Guidelines: 1. Verify Physicians orders.8. Assess patient HR (Heart Rate)/RR (Respiration Rate)/ SaO2 Lung sounds 9.Remove and discard soiled dressing, note drainage and assess stoma site suction trach if necessary.25.Reasses the patient. Using the procedure for tracheostomy suction, suction the resident if needed. Review of the record revealed Resident #223 was admitted to the facility 01/27/26 with diagnoses of Anoxic Brain Damage (when the brain is completely deprived of oxygen, causing brain cells to begin dying)and acute respiratory failure with hypoxia. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #223's Brief Interview for Mental Status (BIMS) was not completed, indicating the resident was severely cognitively impaired. This same MDS indicated Resident #223 received treatments such as tracheostomy care, oxygen therapy, and suctioning. Review of Resident #223's active orders revealed the following: Oxygen Inhalation (via trach collar @ 4lpm as tolerated every shift (Active).Trach care every shift and as needed. Changed gauge around trach flange. as needed trach care AND every shift (Active)Suction trach every shift and as needed as needed suction trach AND every shift (Active) Review of Resident #223's care plan dated 01/28/26 documented Focus: The resident has a Tracheostomy. Goal: The Resident will have no complications, to the extent possible, related to the tracheostomy status through the next review date; Interventions: Monitor/document/Report respiratory status and notify provider of abnormalities observed/reported; Obtain/document/report vital signs as ordered and as needed. Notify provider of abnormal results; Provide suctioning as ordered/tolerated. A tracheostomy care observation for Resident #223 was conducted on 02/11/26 at 1:00 PM with Staff C, Licensed Practical Nurse (LPN). Upon entering the room Staff C performed hand hygiene and donned Personal Protective Equipment (PPE) which included a gown and gloves. Staff C began by setting up her supplies and continued with tracheostomy care. A respiratory assessment was not performed by Staff C. Staff C began to clean Resident#223's trach collar and during the process the resident began to cough and expel secretions and a mucus plug was visualized. Staff C wiped off the secretions on top of the trach canula and the Resident continued to cough and small amounts of secretions were expelled across the room. Staff C verbalized that she should suction the Resident; Staff C did not suction Resident #223. Staff C checked the Resident's pulse oximetry and stated, oh its 97%. Staff C concluded her care, discarded her supplies, and washed her hands. Staff C was asked if she was done with her care and stated yes then walked out of Resident #223's room. Again, Staff C did not perform a respiratory assessment on Resident #223. A follow up interview was conducted on 02/11/26 at 1:25 PM, when asked who normally provides tracheostomy care, Staff C stated she didn't work everyday but the nurses normally provide care and the Respiratory Therapist trained them. Staff C stated this was the first time she performed tracheostomy care by herself on a Resident and last time she trained for it was back in 2022. When asked if she had a competency for performing tracheostomy care at this facility, Staff C stated she did not remember if she had one. When asked how do you perform a respiratory assessment, Staff C stated she would listen to lung sounds and check the oxygen. When asked when she would perform one, Staff C stated anytime and that there was no specific time and then stated when the resident is in distress. When asked if she should perform one before and after tracheostomy care, Staff C agreed. When asked why she didn't perform it, she stated because I only did a dressing change. When asked when would you suction a Resident, Staff C stated when there is phlegm coming out. When asked if she saw any secretions coming out of the Resident, Staff C stated a little bit. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked if there was a reason she did not perform suctioning she stated she was nervous; Staff C stated she knew how to suction and perform respiratory assessments but did not due to being nervous. Staff C then stated she had never suctioned Resident #223 before and the Respiratory Therapist had been doing it. Review of Staff C's competency titled Trach Care Competency Validation dated 01/28/26 documented, 1. Verify Physicians orders.8. Assess patient HR /RR / SaO2 Lung sounds 9. Remove and discard soiled dressing, note drainage and assess stoma site suction trach if necessary.25. Reassess the patient. Using the procedure for tracheostomy suction, suction the resident if needed. Employee performance is . Acceptable. All skills were verified and signed off by the evaluator, Staff F, RT (Respiratory Therapist) on 01/28/26. During an interview with the Administrator and Director of Nursing (DON) on 02/11/26 at 02:10 PM when asked if all nurses had competencies in tracheostomy care, the Administrator stated the training started on the Med bridge area (short-term care) and the training was ongoing; their goal was for all nurses to be trained. The Administrator stated this training started approximately 4 months ago and they have had 3 tracheostomies since. He stated Staff F was here from Monday to Friday for about 8 hours a day and also on call. During an interview on 02/12/26 at 10:44 AM, when asked how she keeps track of the nurses she has trained on tracheostomy care, Staff F stated she knows them by face but they had a roster that the ADON helped keep track of. When asked how she trained the nurses with tracheostomy care, Staff F stated they had a mannequin, but they also practiced on the actual Resident. Staff F stated the nurses can receive training whenever they want and were able to call her; she stated, she made sure to mark off new nurses and nurses who are per diem since they don't see them everyday. Staff F stated the nurses who are assigned Tracheostomy Residents must be trained. When asked how she performed a competency with a nurse in tracheostomy care, Staff F stated she performed the skill, she asked for return demonstration and then checked them off. When asked what must be done to consider a nurse competent in tracheostomy care, Staff F stated everything on the check list must be done and signed off, if they miss a step they are stopped and must perform it until done properly. During an Infection Control interview on 02/12/26 at 11:09 AM, when asked during tracheostomy care what PPE (Personal Protective Equipment) do you expect to see the nurses wearing, the ADON (Assistant Director of Nursing) stated gown, gloves, and a mask. When asked if she would expect to see any other PPE, the ADON stated if you expect splashing of fluids, a shield too. When asked if she rather them perform tracheostomy care with a shield or eye cover if they don't expect splashing, she agreed. The ADON was made aware Staff C did not perform any respiratory assessments or suction Resident #223 while performing care, she agreed with all findings and stated the nurses needed to receive more education.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105496	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Isles of Boynton Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 South Congress Avenue Boynton Beach, FL 33426	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure only authorized staff have access to treatment carts for 6 out of 6 treatment carts, failed to ensure med carts are locked at all times for 1 out of 8 med carts, and failed to ensure mediations were secured at the bedside for 1 of 39 sampled residents (Resident #155). The findings included:Review of the facility's policy titled, Clinical - Medication Storage and Labeling with a revised date of 12/09/25 included in part the following: Medications and biologicals in medication rooms, carts, boxes, and refrigerators are to be maintained within secured (locked) locations, accessible only to designated staff. 1) On 02/11/26 at 9:30 AM an observation of wound care performed by Staff A Wound Care Registered Nurse (WCRN) who was assisted by Staff B, Certified Nursing Assistant (CNA), for Resident #21. Upon completion of the wound care, Staff A, WCRN, gave his keys (with keys to all med treatment carts) to Staff B, CNA, to stock the medication treatment carts. During an interview conducted on 0211/26 at 10:35 AM with Staff A, WCRN, who was asked about giving his keys to the treatment carts to Staff B, CNA, Staff, AWCRN, stated this is how they do it, she is a part of his team. When asked if she is authorized to have access to the wound treatment carts, he stated again, she is part of my team, yes of course she is. During an interview conducted on 02/11/26 at 10:40 AM with Staff B, CNA, who was asked if she was authorized to have the keys in her possession for the med treatment cart, she simply said she was going to restock the med treatment carts. During an interview conducted on 02/11/26 at 10:55 AM with the Director of Human Resources she confirmed Staff B, CNA, is not a Qualified Med Tech and there is nothing in her job description about being authorized to have access to medications, including treatment carts. 2) Record review for resident #155 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Displaced Avulsion Fracture (Chip Fracture) of Left Talus, Pressure Ulcer of Other Site, Acute Kidney Failure, and Type 2 Diabetes Mellitus. The Minimum Data Set assessment dated [DATE] documented in Section C a Brief Interview of Mental Status score of 15, indicating a cognitive response. Review of the Resident's record revealed no assessment for self-administration of medications. Review of the Physician's Orders for Resident #155 revealed in part the following: An order dated 12/21/25 for Ascorbic Acid Tablet 500 MG, give 1 tablet by mouth one time a day for wound healing.There was no orders for any of the following: Vicks [NAME] Nasal Solution 0.05 %, Magnesium Gummies 336 mg, Tension headache relief acetaminophen 500 mg/65 mg, Tums extra strength 750 mg, Benadryl Allergy Tablet 25 MG (Diphenhydramine HCl). On 02/10/26 at 9:07 AM during a medication pass observation for Resident #155, performed by Staff H, Licensed Practical Nurse (LPN) there on the Resident's overbed table in an open clear container were several over the counter medications including: Magnesium Gummies 336 mg, Tension headache relief acetaminophen 500 mg/65 mg , Tums extra strength 750 mg, Benadryl Allergy Tablet 25 MG (Diphenhydramine HCl), and Vicks [NAME] Nasal Solution 0.05 %. On 02/10/26 at 9:25 AM, during a side by side observation with Staff H, LPN, she acknowledged the medications at the bedside for Resident #155, and acknowledged the resident had no order or assessment for self-administration. 3) During a medication pass observation made on 02/10/26 at 9:07 AM with Staff H, Licensed Practical Nurse (LPN), for Resident #155, the nurse left the medication cart unlocked and unattended when she entered the resident's room to administer the medications. During an interview conducted on 02/10/26 at 9:10 AM with Staff, H LPN, who acknowledged she left the med cart unlocked and unattended when she went into Residents #155's room to administer the medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105496	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Isles of Boynton Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 South Congress Avenue Boynton Beach, FL 33426	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to serve ground meats, per the physician's diet order. This had the potential to affect 1 of 1 sampled resident, who was on a regular texture diet with ground meats (Resident #103). The findings included:A record review revealed that Resident #103 was admitted to the facility on [DATE]. He has received Hospice services since 09/09/2022. His admitting diagnoses included Cerebral Atherosclerosis, Unspecified Dementia, Unspecified Severity, with other Behavioral Disturbance, and Sarcopenia (muscle wasting). The resident's diet listed in the electronic medical records was for a Regular diet, with Regular texture food, Regular/Thin Liquids consistency, and Ground Meat since 08/06/25. A nutrition progress note dated 08/06/25 revealed that Resident #103's daughter requested that ground meats were added to his diet for ease of chewing. A record review of the Resident #103's diet in the meat ticket program's listing (Dietary List) of diets showed that Resident #103 was on a Regular diet, with Regular texture food, and Regular/Thin Liquids. It did not show that Resident #103 had a diet order for ground meats.Photographic Evidence Obtained An observation on 02/09/26 at 1:05 PM revealed Resident #103 was in bed chewing on something big. The surveyor greeted the resident, and the resident removed brown chewed-up food from his mouth. He held it in his hand and it looked like a half of a small hamburger. There was no tray of food in the resident's room. The surveyor went into the hallway and spoke to the CNA (Certified Nurses Aide) who said she just finished feeding Resident #103. When asked to see the tray of food that he ate from, the CNA removed the tray from the top shelf of the cart. The tray was identified by the meal ticket that had the resident's name and diet printed on it. The meal ticket specified that Resident #103 was on a regular diet, with regular texture foods, and thin fluids. The resident was served regular texture beef pot pie. The plate of his leftover food had a couple of chopped carrots, peas, several green beans, and approximately 2 ounces of stringy beef. The beef should have been ground. The meal ticket had no mention of the diet order that included ground meat. Photographic Evidence Obtained. An interview on 02/09/26 at 1:10 PM, with Staff G revealed that sometimes the CNA's place meat in a piece of bread to facilitate independent feeding. She removed the chewed up food from the resident's hand. She said that Resident #103's daughter wanted him to feed himself when he can. Photographic Evidence Obtained. An observation on 02/10/2026 at 8:20 AM revealed that Resident #103 was served 2 whole waffles, a bowl of corn flakes, and 2 whole round sausage patties. The food served to Resident #103 matched the diet that was printed on his meal ticket. The sausage patties should have been ground. Photographic Evidence Obtained. An interview revealed that Staff I believed that she knew the resident's prescribed diet by reading the diet that was printed on the meal tickets. When asked if the resident's diet was also listed on the Kardex, (the point of care data system that CNA's use to enter details about how much food was eaten), the CNA searched the Kardex. The resident's diet was not listed in the Kardex. When the CNA was made aware that the resident's diet order in the electronic medical records specified ground texture meats, the CNA said she would alert the kitchen about the discrepancy between the diet listed on Resident #103's meal ticket, and the diet in the resident's medical record. Staff I said she would request ground sausage meat for Resident #103.