STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105506	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER: Encore at Boca Raton Rehabilitation and Nursing Ce		STREET ADDRESS, CITY, STATE, ZIP CODE: 7300 Del Prado Circle South 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on record review, observations and interviews, the facility failed to provide a safe environment to the residents as evidenced by allowing a visitor to enter the facility at 6:14 AM, without properly identifying the visitor. The findings included: Review of the facility's policy titled, Visitation revised on 08/2022 provided by the Administrator documented . the facility provides 24-hour access to individuals visiting .some visitation may be subject to reasonable clinical and safety restrictions that protect the health, safety, security and/or rights of the facility's residents such as: keeping the facility locked or secured at night with a system in place . On 06/25/24 at 6:14 AM, the surveyor arrived at the facility's main entrance, rang the doorbell and the automatic door opened. The surveyor walked up to the reception desk and completed the registration/sign-in using the facility's Advanced Registration machine at the reception desk. Observation revealed no staff member at the reception desk and no staff member came to the main entrance to greet or identify the surveyor. The surveyor proceeded to enter the elevator and with no elevator code required, the surveyor arrived at the facility's second floor, the long-term care units. On 06/25/24 at 6:18 AM, the surveyor arrived at the facility's Windsor Unit on the second floor. An interview was conducted with Staff A, Registered Nurse (RN) who stated he has been working in the facility for two months on the 11:00 PM-7:00 AM shift. Staff A was asked if he opened the main entrance door for the surveyor and replied he did not. Staff A further stated the resident's family members can visit the resident at any time of the day. On 06/25/24 at 6:22 AM, an interview was conducted with Staff B, RN in the Windsor unit. Staff B was asked who was in charge and stated that they did not have a supervisor during the night shift and that all nurses were in charge. Staff B was asked if she opened the main entrance door for the surveyor and replied she did not. Staff B was asked to contact the manager on duty. On 06/25/24 at 6:32 AM, an interview was conducted with Staff C, RN in the [NAME] Unit on the first floor, who stated she has been working in the facility since 02/2024 on the 11:00 PM- 7:00 AM shift. Staff C was asked if she opened the main entrance door for the surveyor and replied she did not hear a doorbell for her to open the door. (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: 105506	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER: Encore at Boca Raton Rehabilitation and Nursing Ce		STREET ADDRESS, CITY, STATE, ZIP CODE: 7300 Del Prado Circle South Boca Raton, FL 33433	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/24 at 7:05 AM, an interview was conducted with Staff D, in the [NAME] Unit, who stated she has been working in the facility for two and half years. Staff D was asked regarding the facility's protocol to follow once someone is at the main entrance door and rings the doorbell for entry. Staff D stated that once she hears the doorbell, she checks the I-pad camera and pointed to the I-Pad located at the nurse's station. Staff D continued to state that if she cannot view the person, she goes to the main entrance door. Staff D added if she does not know who the person is, she would not let the person in. Staff D stated she then will ask their name and what they are there for, check the resident record to make sure the person is listed, then she lets them come in. Staff D stated she did not open the entrance main door this morning for the surveyor's entry. On 06/25/24 at 7:12 AM, an interview was conducted with Staff E, RN in the [NAME] Unit- first floor who stated she has been working in the facility for nine months on the 11:00 PM-7:00 AM shift. Staff E was asked regarding visitors during her shift and stated that usually they don't let people in at night unless the resident is on hospice. The hospice staff calls the family, and they may come at night. Staff E pointed to an I-Pad located at the nurse's station and stated that it works 95% of the time, added sometimes she could open the main entrance door for the Pharmacy person, and the X-ray Technician or the Phlebotomist. Staff E stated she did not open the entrance main door this morning for the surveyor's entry and added probably someone in the [NAME] Unit may have. On 06/25/24 at 7:47 AM, an entrance conference was conducted with the facility's Administrator. During an interview, the Administrator was apprised that someone opened the automatic main entrance door remotely for the surveyor to enter the facility at 6:14 AM. The Administrator was informed that no staff member came to the door to identify the surveyor, and no one asked questions before allowing entry. The Administrator stated the staff should have come and opened the door for the surveyor. He added there was a camera at the first-floor unit and there was an intercom, and the staff was able to speak to the surveyor via intercom. The Administrator was asked to submit a copy of the facility's Protocol related to letting visitors in during the 11:00 PM-7:00 AM shift. The Administrator provided the facility's Visitation policy. On 06/25/24 at 12:50 PM, during an interview, the Administrator stated they were able to identify the staff member who opened the door to the surveyor and added the staff will be educated regarding the process of letting a visitor in the facility after hours. On 06/26/24 at 4:10 PM, during an interview, the Administrator stated that the facility had a front desk person from around 7:30 AM to around 9:00 PM; if a visitor comes after 9:00 PM and before someone is at the desk, the [NAME] unit staff was the only unit able to let someone in. The Administrator stated the staff will come to the front desk, instruct the person to complete a questionnaire on the Advanced entry machine and direct them to the room.

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	105506	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore at Boca Raton Rehabilitation and Nursing Ce	7300 Del Prado Circle South Boca Raton, FL 33433

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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** 36057 Based on observation, record review and interview, the facility failed to ensure that a resident received wound care consistent with professional standards of practice for 1 of 1 sampled resident for wound care (Resident #3). The findings included: Review of the facility's policy titled, Wound Care revised on 10/2010 documented .use disposable cloth (paper towel is adequate) to establish a clean field on resident's overbed table, place all items to be used during the procedure on the clean field .put on exam glove, loosen tape and remove dressing, pull glove over dressing and discard into appropriate receptacle, wash and dry hands thoroughly, put on gloves .use no-touch technique .pour liquid solutions directly on gauze sponges .apply treatment as indicated .dress wound .be certain all clean items are on clean field .use clean field saturated with alcohol to wipe overbed table . take only the disposable supplies that are necessary for the treatment in the room . Review of Resident #3's clinical record documented an admission on 03/25/00 and a readmission on 01/31/23. The resident's diagnoses included Quadriplegia, Anoxia Brain Damage, Diabetes Mellitus Type 1, Contractures, and Neuromuscular Dysfunction of Bladder. Review of Resident #3's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 0, indicating that the resident had severe cognition impairment. The assessment documented under Functional Abilities and Goals showed that the resident was dependent on the staff to complete the activities of daily living. Review of Resident #3's Wound Care Specialist note dated 06/19/24 documented a Stage 3 Right buttock pressure wound with measurements as 3.4 centimeters (cm) length by 3.3 cm width by 0.4 cm depth. The pressure wound was acquired while in the facility. Review of Resident #3's physician order dated 06/19/24 documented, Cleanse right buttock with normal saline, apply Leptospermum Honey and calcium alginate topically, cover with foam dressing, change daily and as needed for wound care. On 06/26/24 at 9:36 AM, wound care observation for Resident #3 performed by the facility's dedicated wound care nurse (WCN) started. Observation revealed the WCN placed on a foam tray, one vial of normal saline solution, an opened tube of Medihoney, one Calcium Alginate with antibacterial Silver 2 x 2 dressing, a few gauze sponges, one bordered dressing, and a pair of scissors from the treatment cart's drawer. The WCN was assisted by Staff F, Certified Nursing Assistant (CNA). On 06/26/24 at 9:40 AM, observation revealed the WCN entered the resident's room and placed the foam tray with the wound care supplies on top of the resident's overbed table without establishing a clean field. The WCN went to the bathroom away from the wound care supplies, to perform hand hygiene, donned gloves and returned to the resident's bedside. Observation revealed the WCN removed the soiled dressing, tightened up the dressing, looked around and placed the dressing on top of the pad underneath the resident. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further observation revealed the WCN did not remove her pair of gloves after the removal of a soiled/dirty dressing. The WCN, with the same pair of gloves, reached the vial of normal saline solution, squeezed the solution into the residents' open wound, reached and opened a sponge gauze packaging, removed the gauze and cleaned the wound. The WCN then reached the Calcium Alginate packaging, removed the alginate gauze and cut up a piece with a pair of scissors. The WCN disinfected the scissors in front of the surveyor prior to use it. Observation revealed the WCN touched and held the calcium alginate gauze with her soiled gloves, applied Medihoney to the alginate gauze and then placed it on the open wound, opened the bordered dressing packaging and applied on top of the calcium alginate gauze. Further observation revealed the WCN, with her soiled pair of gloves, reached to her uniform pocket, pulled a sharpie marker to write on the bordered dressing. Furthermore, observation revealed the WCN retrieved the soiled dressing she placed on the bed pad underneath the resident, with her gloved hand and stated she will throw it away. The WCN discarded the foam tray and soiled dressing into a trash container bag in the bathroom, placed the scissors and the Medihoney tube on top of the sink, removed her gown, performed hand hygiene then carried the scissors and the Medihoney tube and placed both on top of the treatment cart. The WCN disinfected the pair of scissors, placed the pair of scissors and the Medihoney tube in the first drawer of the treatment cart. Resident #3's wound care was completed at 9:53 AM. On 06/26/24 at 9:54 AM, an interview was conducted the WCN who was asked when she would change gloves during the procedure and stated she will change gloves if the wound was bloody. The WCN was asked again to state the wound care procedure and stated she will remove the soiled/previous dressing and will put on a new pair of gloves because she will do a new dressing and does not want to introduce bacteria to the wound. The WCN stated she should not put the Medihoney tube back in the cart because of the risk of infection, and it should be left in the resident's room. On 06/26/24 at 1:34 PM, during an interview, the Assistant Director of Nursing (ADON) was apprised of the wound care observations findings. The ADON stated the WCN had to change gloves after the removal of the soiled/previous dressing and that the Medihoney should not be put back in the treatment cart once it was in the resident's room.