

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Grand Boulevard Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 138 Sandestin Lane Miramar Beach, FL 32550	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51224</p> <p>Based on observation, resident interview, staff interview, record review and policy review, the facility failed to ensure the interdisciplinary team assessed and determined a resident was capable of self-administration of medications prior to allowing 1 of 19 sampled residents to self-administer medications. (Resident #67)</p> <p>The findings include:</p> <p>An observation of Resident #67 was conducted on 02/17/25 at 10:35 AM. A medicine cup with 4 pills was observed sitting on the over bed table. When asked about this, the resident stated, If a nurse is in a hurry, then they leave the medication at the bedside, but they never watch me take my medications.</p> <p>A telephone interview was conducted with Employee C (a Licensed Practical Nurse) on 02/19/25 at 2:01 pm. She stated that she normally doesn't work on Resident #67's hall. She stated that she doesn't remember leaving the medications with the resident but, if she did, then it was an error on her part. She did not watch the resident take the medications. She is not sure if the resident is evaluated to self-administer her medications.</p> <p>A review of the resident's electronic medical record revealed no documentation discussing self-administration of medications. A review of the admission minimum data set with an assessment reference date of 12/24/24 revealed the resident had a BIMS (brief interview of mental status) of 15 indicating she is cognitively intact.</p> <p>A review of the policy Self-Administration of Medication, dated [DATE], states the following, A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician and approved by the Interdisciplinary Care Plan Team.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28603</p> <p>Based on record review, staff interviews, and policy review, the facility failed to ensure the minimum data set (MDS) accurately reflected the resident's status for 1 of 1 sampled residents reviewed for pressure ulcers (Resident #57) and 1 of 1 sampled residents reviewed for hospitalization . (Resident #83)</p> <p>The findings include:</p> <p>Resident #57</p> <p>A review of Resident #57's electronic record revealed the Medicare 5-day MDS with an assessment reference date (ARD) of 2/3/25 indicated in section M that the resident had two stage 2 pressure ulcers present upon admission or re-entry. A review of the weekly wound documentation dated 1/31/25 revealed the right heel and sacral area had stage 2 pressure wounds that were facility acquired.</p> <p>An interview was conducted with Employee A (MDS Coordinator Registered Nurse) on 2/19/25 at 1:32 PM. Employee A reviewed the MDS dated [DATE] and the wound records dated 1/31/25 and confirmed the stage 2 pressure wounds on the right heel and sacrum should have been coded as facility acquired on the MDS.</p> <p>Resident #83</p> <p>A review of Resident #83's electronic record revealed a discharge MDS with an ARD of 1/20/25 that indicated in section A that the resident was discharged to a short-term general hospital. A review of the record revealed the resident was actually discharged to hospice. The record did not indicate the resident was ever hospitalized .</p> <p>An interview was conducted with Employee B (Registered Nurse Risk Manager) on 2/19/25 at 9:11 AM. Employee B stated the MDS was not correct, and the resident went home on 1/20/25 with hospice care.</p> <p>Review of the facility policy for Certifying Accuracy of the Resident Assessment (dated October 2010) revealed all personnel who complete any portion of the Resident Assessment must sign and certify the accuracy of that portion of the assessment.</p>		