STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105601	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Boulevard Health and Rehabilitation Center	138 Sandestin Lane Miramar Beach, FL 32550

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations, staff interviews, and a review of the facility's workˆorder logs, the facility failed to maintain a clean, comfortable, and homelike environment for residents.The findings include: 1. During a tour of the facility conducted on 05/27/2026 at approximately 11:00 AM, it was noted in room [ROOM NUMBER] that five ceiling tiles were bowing from the ceiling and the paint above the wallˆmounted airˆconditioning unit appeared warped and peeling. (Photographic evidence obtained) On 05/27/2026 at approximately 11:30 AM, the airˆconditioner (AC) vents were observed actively dripping condensation from the ceiling onto the floors in the hallways near Rooms 210, 204, 503, 501, 408, 404, 402, and 206 while maintenance staff replaced ceiling tiles. Dust accumulation was observed in the vents in the main conference room and in the hallways near rooms [ROOM NUMBERS]. A leak in the common television area was also noted, with water seeping through ceiling tiles and light fixtures. (Photographic evidence obtained) During an interview with the Maintenance Director conducted on 05/27/2026 at approximately 1:56 PM, he stated he was aware of ongoing condensation and AC issues throughout the building and had been addressing them as quickly as the corporate budget allows. He confirmed that he was the only maintenance staff member for the facility. Review of the Maintenance Workˆ Order Report revealed longˆstanding issues, beginning with a rooftop AC unit on the 600 hall that had been out of operation since 06/25/2024. Additional unresolved issues included an AC unit being out of operation in the facility's common area since 04/28/2025, lack of proper cooling in the laundry room since 06/12/2025, a rooftop unit being out of operation in the rehabilitation gym since 11/10/2025, and a rooftop hallway AC unit being out of operation in the 1000 area since 12/12/2025. More recent issues included an AC electrical problem reported on 05/22/2026. Nine work orders related to ceiling tiles were also noted. During an interview with the Administrator and Regional [NAME] President conducted on 05/28/2026 at approximately 1:00 PM, they reported being aware of the ongoing AC issues since 06/25/2024, confirming the AC units were not functioning at full capacity. They provided correspondence dated 08/01/2025 acknowledging the AC problems and requesting funding for repairs. The Administrator stated they recognized the concern with the approaching summer heat. 2. On 05/26/2026 at approximately 12:45 PM, two unlabeled wash basins were observed on the floor under the sink in the bathroom of room [ROOM NUMBER]. One wash basin contained a toilet insert designed to catch urine for measuring or testing. Dried brownish fluid stained the wall next to the wash basins. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/26/2026 at approximately 1:00 PM, a water pitcher was observed holding an uncovered toothbrush and uncapped toothpaste on the bathroom sink in room [ROOM NUMBER]. On the other side of the sink sat a tube of toothpaste in a clear cup and a water pitcher. None of the items were labeled. Follow-up observations were made on 05/28/2026 at 9:45 AM of the bathrooms in rooms [ROOM NUMBERS]. It was noted that staff had not removed the wash basins or urine collecting toilet insert and the wall remained stained in room [ROOM NUMBER]. Staff had not labeled the toothpastes, toothbrush, or water pitcher, and the items remained unchanged in room [ROOM NUMBER]. On 05/28/2026 at 10:07 AM, room [ROOM NUMBER] was toured with the Environmental Services Director (EVS Director). When asked how often staff clean the resident's bathrooms, the EVS Director stated that housekeeping cleaned daily, wiping down high touch areas including sinks and the toilet. The EVS Director stated that staff cleaned the walls during deep cleaning, which occurred when a resident was discharged , passed away, or when the cleaning staff identified an issue. An interview was conducted with Staff N, Certified Nursing Assistant (CNA) on 05/26/2026 at approximately 1:05 PM regarding the unlabeled items in the bathroom of room [ROOM NUMBER]. When asked why the items were not labeled, Staff N stated that neither resident used the bathroom and they were not sure why those items were left there or who they belonged to. A follow up interview was conducted with Staff N on 05/28/2026 10:16 AM regarding the wash basins on the floor in the bathroom of room [ROOM NUMBER]. Staff N stated they were not sure why staff had left the basins on the floor. When asked about the facility's policy regarding storing resident care equipment such as wash basins in a sanitary manner, Staff N stated that staff should label wash basins with the resident's name, place them in a plastic bag, and store them in the drawer in the resident's room. An interview was conducted with the Director of Nursing (DON) on 05/28/2026 10:25 AM regarding her expectations for storing resident care equipment in a sanitary manner. The DON stated that staff should rinse and dry resident care and personal hygiene items such as wash basins, label them, place them in a plastic bag, and store them with the resident's belongings. When a policy was requested on storing resident care equipment, the DON stated the facility did not have a policy. 3. Upon entering the facility's nursing unit hallways on 05/26/2026 at 10:00 AM, a notable foul sewage-like odor was noted. Similarly, while in the facility's main conference room, the same foul odor was noted. The sewage-like odor was noticeable and pungent throughout the survey process. During observations conducted on 05/26/2026, 05/27/2026, and 05/28/2026 on the 500 and 600 units, the following issues were noted: The hallway was observed with ceiling air vents open and uncovered, ceiling tiles bowing from the ceiling, and with black, greenish brown discoloration on them. room [ROOM NUMBER] had broken tiles next to the bed sitting by the window, and a broken dresser. The bathroom flooring was visibly stained, unclean, with a blackish brown discoloration observed at the base of the toilet. room [ROOM NUMBER] had cracks in the wall by the window, cracks in the flooring and on the wall (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by the air conditioner unit, a rusted three-in-one toilet, a blackish substance in a basin sitting on the bathroom floor, rusted pipes behind the toilet, and stained flooring, room [ROOM NUMBER] had a blackish brown discoloration observed at the base of the toilet and rusted fixtures on the shower wall. room [ROOM NUMBER] had broken furniture, in the bathroom the tub was visibly dirty with used wash cloths lying in the tub, water damage on the wall next to the air conditioner unit, with a black colored substance underneath the air conditioner unit. room [ROOM NUMBER] had hanging lights around the ceiling. room [ROOM NUMBER] was noted to have a brownish discoloration surrounding the base of the toilet and bathroom floors were stained. room [ROOM NUMBER] had broken furniture and clutter with debris on the floor by the resident's bed. The bathroom had cracked ceiling tiles around the sprinkler head, rusted pipes on the wall behind toilet, and a rusted three-in-one toilet. room [ROOM NUMBER] had visible brownish discoloration in three different areas on ceiling tiles in the bathroom. An interview was conducted with the Environmental Services Manager on 05/28/2026 at 11:00 AM. He described the job duties of housekeepers and duties of housekeeping staff. He explained they had a routine cleaning schedule but that they target rooms for residents who tend to have more messes due to dropping food and snacks and spilling drinks on the floor. He further stated if a room required repairs, if it was minor, he would try and help fix those items. The Environmental Manager stated room [ROOM NUMBER] was an example of a target room. When asked about the leaks throughout the facility, he stated the leaks occurred around the AC returns, mostly on the 400 and 600 units. He stated the AC returns had been leaking a while. Probably I would say about 6 months, they have replaced two of the units on the roof, but the new company has yet to replace the others. The roof is flat and the roof-top units leak are not working correctly, also when it rains a lot we get leaks. Upon asking about the foul smell he stated, The pipes are cast iron, there used to be a restroom next door to this conference room, however, it was converted into a nutrition room. If the pipes have an air leak or gas leak, the odor you are smelling is coming from that. An interview was conducted with the Maintenance Director on 05/28/2026 at 12:30 PM. He stated one of the roof-top AC units needed to be replaced. He stated, We are waiting for the final approval from corporate. The PTACs (personal air conditioning units in each room) are working overtime causing water leaks in the facility, mainly on the 400, 500, and 600 units. When asked about the foul sewage smell, he stated he believed it's from a leak from the pipes. He did not offer a solution or repair plan about this issue.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observations, interviews, and record reviews, the facility failed to review and revise care plans after the comprehensive and quarterly assessments were completed for 2 out of 2 residents reviewed (Resident #9 and #4) The findings include:1. A record review was conducted on for Resident #9. Documentation revealed Resident #9 was admitted to the facility on [DATE] with a diagnosis of a Stroke with right side paralysis and contracture. During review of Resident #9's plan of care, it was noted that an alteration in metabolic balance related to diabetes was initiated on 12/13/2021 with interventions dated for revision on 07/26/2025. Further review of the record indicated that Resident #9 was under the care of an endocrinologist and was started on insulin coverage in April 2026 due to elevated labs and blood sugars. This change in status was not reflected in the plan of care. Additionally, a plan of care was initiated on 12/10/2021 for alteration in activities of daily living (ADL) with interventions that included per therapy [Resident #9] is independent with standby assist by staff for all transfers and ambulation with a walker or cane. The last revision date for this plan of care was 07/26/2025. Therapy notes revealed that on 12/19/2025 through 01/17/2026, Resident #9 received physical therapy services due to a noted decrease with functional capacity, decrease in bilateral lower extremity strength, decline in ambulation and transfer ability, a decrease in balance and coordination impairing safety. On 02/17/2026 through 03/18/2026, a therapy evaluation was completed, and it was documented that therapy was needed for teaching adapting techniques to promote safety awareness, minimize falls, increase lower extremity strength and range of motion, and to decrease level of assistance from caregivers to enhance quality of life. This was not reflected in Resident #9's plan of care.2. A record review was conducted on for Resident #4. Documentation revealed Resident #4 was admitted to the facility on [DATE] with the diagnoses of a wedge compression fracture of the lumbar and thoracic spine, diabetes, and below the knee amputation. A plan of care was initiated for Resident #9 on 08/25/2025 for potential for adverse side effects of psychotropic medications, antidepressants, and antianxiety medications, with no revision date beyond 08/25/2025 for interventions and plan of care. According to the current physician orders, Resident #9 was not prescribed to take antipsychotic medications at the time of the survey.A plan of care was initiated on 08/25/2025 for alteration in ADL function and indicated that Resident #4 required assistance from staff with bed mobility, transfers, dressing, eating, and personal hygiene due to decreased mobility and above knee amputation bilaterally, with current interventions that included weight bearing as tolerated of 2 for bed mobility and weight bearing assist of 2 plus mechanical lift for all transfers initiated on 12/09/2025. A plan of care was initiated on 08/28/2025 with a revised date of 12/09/2025 that stated Resident #4 was at risk for falls related to assistance with transfers, had unsteady gait (ambulation) with the intervention to observe residents' ambulation for steadiness, balance, muscle coordination, and ability to reposition and turn.During observations and interviews conducted on 05/26/2026, 05/27/2026, and 05/28/2026, Resident #4 was not able to ambulate, he did not have any prosthetics available in his room, and he stated he preferred not to get out of bed most days.An interview was conducted with the facility Regional Nurse on 05/28/2026 at 10:02 AM. She stated the Minimum Data Set Coordinator was responsible for gathering data with the clinical team to ensure each resident's functional and cognitive abilities were accurate prior to completing an annual or quarterly assessment. Given the time to independently review the care plans for Residents #9 and #4, the Regional Nurse acknowledged that the current care plans did not reflect the current care status of these two residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure appropriate infection control practices were followed for 3 of 3 residents reviewed for infection control. (Residents #99, #38 and #48)The findings include: 1. An observation of Percutaneous Endoscopic Gastrostomy (PEG) tube care was conducted for Resident #99 on 05/27/2026 at approximately 11:44 AM. (A PEG tube is used to provide longˆterm nutrition for individuals who are unable to eat orally) Staff A, a Licensed Practical Nurse (LPN), was observed performing hand hygiene and donning gloves before the procedure; however, no gown or mask was worn. Hand hygiene was performed again after Staff A completed the care. During an interview following the observation, Staff A stated that Enhanced Barrier Precautions (EBP-an infection control measure requiring staff to wear gowns and gloves during high-contact care) were required during high-contact activities such as PEG tube care, urinary catheter care, and wound care. Staff A demonstrated where the PPE carts were located in each hallway. At about 12:00 PM, Staff D, a Unit Manager, was interviewed, and was asked what Personal Protective Equipment (PPE-the protective gear staff wear to keep themselves and residents safe from germs and infections) should be used when giving care to a resident with EBP. Staff D stated that a gown, gloves, and mask were required during cares. At this time it was observed that an EBP sign was visible outside of Resident #99's room. Review of Resident #99's medical record revealed there was an active physician order for Enhanced Barrier Precautions (EBP) due to the risk of transmitting Multiˆ Drug Resistant Organisms (MDRO) through the PEG tube. Further record review revealed the care plan listed EBP interventions that included educating the resident and representative, ensuring staff follow EBP protocol guidelines, performing hand hygiene per protocol, maintaining PPE and EBP equipment outside the resident's room, and placing appropriate EBP signage on the door. An interview was conducted with Staff F, LPN on 05/28/2026 at approximately 12:00 PM regarding her understanding of EBP. She explained that she associates these precautions with situations involving an active infection, similar to Droplet Precautions, during which she would wear a gown, mask, and gloves. When asked whether any residents currently had active infections, she stated they did not. She further reported that for routine urinary catheter care and PEGˆtube care, she used only hand hygiene and gloves, as her residents did not have active infections. Staff F noted that she cared for one resident with a urinary catheter and one with a PEG tube and confirmed that she continued to follow only hand hygiene and glove use before and after care for these residents. A follow-up interview with Staff A conducted on 05/28/2026 at approximately 12:08 PM. She acknowledged that she did not wear the appropriate PPE during PEG tube care for Resident #99 and that she had realized her mistake after completing the care. A review of the facility's policy titled Feeding Systems (last review date June 2025), indicated that protective barriers may include handwashing, gloves, gowns, masks, and goggles, as indicated. 2. On 5/26/26 at approximately 10:45 AM, observations were made of indwelling urinary catheters for Resident #38 and Resident #48. During these observations, it was noted that there was no signage posted for EBP on the doors of either resident. It was further noted that there was no PPE available immediately near or outside either of the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Staff I, Certified Nursing Assistant (CNA) on 05/27/2026 at approximately 10:50 AM. Staff I stated she would wear a gown and gloves when providing catheter care for the residents. Staff I was able to locate gloves but not gowns near or outside either of the resident's room. An observation was conducted of Staff G, LPN providing urinary catheter and wound care for Resident #38 on 05/27/2026 at approximately 11:30 AM. During the care, Staff G was noted only wearing gloves, not a gown. Staff G stated she was unaware of what Enhanced Barrier Precautions meant. Staff G further stated she performed hand hygiene and only wore gloves when providing urinary catheter or wound care to residents. A follow up observation was conducted with Staff H, Unit Manager on 05/27/2026 at approximately 11:45 AM. Staff H confirmed signage for EBP along with PPE needed to be placed outside the doors of Resident #38 and Resident #48. Staff H stated a sign would be posted. Review of Resident #38's clinical record revealed they were admitted to the facility on [DATE]. Further review revealed an active physician's order for Enhanced Barrier Precautions. The Comprehensive Care Plan included a care plan focus area for Enhanced Barrier Precautions with interventions. (Photographic evidence obtained.) Review of Resident #48's clinical record revealed they were admitted to the facility on [DATE]. Further review revealed an active physician's order for Enhanced Barrier Precautions. The Comprehensive Care Plan included a care plan focus area for Enhanced Barrier Precautions with interventions. (Photographic evidence obtained.) A review of facility's policy titled Enhanced Barrier Precautions (dated 4/1/24) indicated the EBP referred to an infection control intervention designed to reduce transmission of MDRO that employs targeted gown and glove uses during high contact resident care activities. Enhanced barrier precautions will be initiated for residents with any of the following: wounds (chronic wounds such as pressure ulcers) and/or indwelling medical devices (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a multidrug resistant organism. Make gowns and gloves available immediately near or outside of the resident's room. (Photographic evidence obtained.)