STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105755	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Nursing & Rehab Center	3600 Old Boynton Road Boynton Beach, FL 33436

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on interviews and record reviews, the facility failed to initiate an immediate report in a timely manner in response to an allegation of abuse by 1 of 1 sampled resident reviewed for abuse, Resident #10. The findings included: The facility's policy, titled, 'Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property', with a reference date of November 2019, documented: Investigation: All suspected cases of abuse or misappropriation of resident's property will be fully investigated by the Administrator, Abuse Coordinator, or designee. The findings should be reported to the appropriate governing agencies. 6. File report to governing agencies. Reporting/Documentation Requirements: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported to the administrator of the center and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care Centers) in accordance with Sate law through established procedures in these time frames: * If the events that cause the allegation involve abuse or result in serious bodily injury, the event must be reported immediately, but not later than 2 hours after the allegation is made. * If the events that cause the allegations do not involve abuse and to not result in serious bodily injury, the event must be reported no later than 24 hours after the allegation is made. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed Resident #10 was admitted to the facility on [DATE]. Review of the resident's most recent complete assessment, a Quarterly Minimum Data Set assessment, dated 01/17/25, documented Resident #10 had a Brief Interview for Mental Status (BIMS) score of 06, indicating Resident #10 had severe cognitive impairment. Resident #10's diagnoses at the time of the assessment included: Cancer, Coronary Artery Disease, Hypertension, Diabetes Mellitus, Hyperlipidemia, Cerebro-vascular accident, Non-Alzheimer's dementia, Anxiety disorder, Depression, Psychotic disorder, Mood disorder, Osteoarthritis, Sarcopenia, Chronic pain, Macular degeneration, Dizziness and Giddiness. Review of the Progress notes documented that Resident #10 was 'alert and oriented times two'. The assessment documented that Resident #10 ambulated via manual wheelchair and required 'Supervision or touching assistance' for bed mobility, and partial/moderate assistance for transfers. Review of Resident #10's care plan for activities of daily living (ADLs) documented, ADL Self-care deficit related to disease process (dementia), physical limitations. Date Initiated: 09/27/2024. The goal of the care plan was documented as, Will be clean, dressed, and well-groomed daily to promote dignity and psychosocial wellbeing. Date Initiated: 09/27/2024; target date 02/14/25. Interventions to the care plan included: o Assist to bathe/shower as needed Date Initiated: 09/27/2024 o Assist with daily hygiene, grooming, nail care, dressing, oral care and eating as needed Date initiated 09/27/24. During an interview, on 03/10/25 at 9:52 AM, when asked about staff mistreating her, Resident #10 replied, She hurt me, and I still feel it (while holding her right arm). I don't know why she has to do that [referring to Staff O, Certified Nursing Assistant / CNA]. During an interview, on 03/11/25 at 9:49 AM, with Staff O, Staff O stated that she does not usually take care of Resident #10, I float around. She cooperates sometimes and sometimes she doesn't. During a follow up interview, on 03/11/25 at 10:34 AM, with Resident #10, when asked if she reported Staff O grabbing her arm, Resident #10 replied, no I don't remember what happened. When asked if her right arm still hurt, Resident #10 replied, my arm doesn't hurt anymore. On 03/11/25 at 10:37 AM, Resident #10 stated, now I remember what I told you. During an interview, on 03/11/25 at 10:41 AM, with Staff P, Licensed Practical Nurse (LPN), when asked about the allegation, Staff P stated that when she was given an explanation of what Resident #10 stated what happened, Staff P immediately went to speak with Resident #10. After speaking with the resident, Staff P was standing at the resident door, came and stated, I'm going to ask the [Staff O]. During an interview, on 03/11/25 at 11:23 AM, the Director of Nursing (DON) confirmed that the incident was reported to her. The DON stated, the nurse reported the incident with the CNA. I haven't spoken to Staff O, because she is on break. The resident stated that she did grab her arm. The social worker and I did a head-to-toe assessment, currently the resident doesn't complain of pain. (continued on next page)

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	105755	A. Building B. Wing	03/13/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview, on 03/11/25 at 1:12 PM, with the DON, the DON stated I spoke with the CNA regarding the complaint from the resident and the CNA said she didn't touch the resident when assisting her with activities of daily living (ADLs), she did everything herself. I did send her home until further investigation. I have also reported the incident for further investigation. During an interview, on 03/13/25 at 3:14 PM, with the Administrator, the DON, and the Regional Nurse Consultant, when asked about reporting the incident, the DON stated, at about 10:45 AM (on 03/11/25), she reported it to me (referring to Staff P). I reported it to DCF (Department of Children and Families) at 11:46 AM and to Law Enforcement at 12:03 PM. Law Enforcement and DCF did not accept the case. We are still investigating it. The Administrator stated, I found that the resident could not determine when the event occurred. She has given me three different answers. The Administrator further stated, the facility's investigation revealed no findings to support Resident #10's allegation . no bruising, no pain, no redness, no changes in behavior, only that she did not want her clothes changed. The Administrator stated that she still had not heard back from the family member. When asked about Staff O, the DON replied, The patient did not complain and she (Staff O) did not touch her because she can put on her own clothes. Staff O's attempts to reposition the resident in a chair was the only opportunity for her to have physical contact with the resident. Her statement was that she did rounds prior to breakfast and approached the resident for breakfast and helped by giving her pants and underpants and did not provide any other assistance to the resident. When asked about filing an Immediate Report to the Agency within 2 hours, the Administrator replied, I was waiting for the case numbers from Law Enforcement and DCF.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51137 Based on observation, interview, and record review, the facility failed to maintain grooming and personal hygiene for 5 of 28 sampled residents, as evidenced by the failure to timely wash the resident's hair for Resident #53 and #17, failure to provide timely incontinence care for Resident #55 and #79, and failure to provide nail care for Resident #80. The findings included: 1.) Review of the record revealed that Resident #53 was admitted to the facility on [DATE] with a primary diagnosis of unspecified Dementia with other behavioral disturbances. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #53 had a Brief Interview for Mental Status (BIMS) score of 0, on a 0 to 15 scale, indicating the resident was severely cognitively impaired. Review of the current care plan initiated on 01/23/25 documented Resident #53 had an ADL deficit related to weakness and decreased functional mobility due to multiple chronic diseases. The goal was will be clean, dressed, and well-groomed daily to promote dignity and psychosocial wellbeing. The interventions included: assist to bathe/shower as needed and assist with daily hygiene, grooming, nail care, dressing, oral care and eating as needed. Review of Resident #53's tasks worksheet revealed her shower/bed bath schedule as following: as needed, Wednesday evenings, and Saturday evenings. Hair washing was documented as completed by Staff H, Certified Nursing Assistant (CNA) on 03/06/25 at 2:43 PM, 03/08/25 at 2:26 PM, 03/09/25 at 2:59 PM, 03/11/25 at 2:52 PM and 03/12/25 at 2:59 PM. Observations were conducted on 03/10/25 at 10:16 AM, 03/11/25 at 9:35 AM, 03/12/25 at 9:30 AM and 03/13/25 at 9:24 AM; Resident #53 was found to have dirty, flat, unkempt and greasy looking hair on all days. During an interview on 03/13/25 at 9:54 AM, when asked when the last time Resident #53's hair was washed, Staff H stated she couldn't remember as it's not on her shift to wash the Resident's hair so it had not been completed. When asked why she had been documenting that it had been completed by her on the electronic record, she stated she wasn't sure. During an interview on 03/13/25 at 10:10 AM, the Assistant Director of Nursing (ADON) was made aware of the concerns relating to Resident #53's hair washing. The ADON stated that Staff H had a language barrier and would talk to her to find out more information regarding the situation. During a follow up interview on 03/13/25 at 10:20 AM, the ADON stated Staff H misunderstood what was asked and stated she had provided Resident #53 a bed bath yesterday that included a washcloth wipe of her hair. When asked If she believed that a washcloth wipe was equal to a hair wash, the ADON agreed that was not the same thing and her hair should have been washed properly, especially since she has a lot of hair. (continued on next page)

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	105755	A. Building B. Wing	03/13/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/13/25 at 11:10 AM, the Director of Nursing (DON) was made aware of the concerns relating to Resident #53's hair washing. The DON agreed with the findings and stated her hair should have been washed properly with more than a washcloth. 2.) Review of the record revealed that Resident #17 was admitted to the facility on [DATE] with a primary diagnosis of Alzheimer's disease. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #17 had a Brief Interview for Mental Status (BIMS) score of 0, on a 0 to 15 scale, indicating the resident was severely cognitively impaired. Review of the current care plan initiated on 03/12/25 documented Resident #17 had an ADL deficit related to weakness and decreased functional mobility due to multiple chronic diseases. Interventions included, Assist with bathe/shower as needed. and Assist with daily hygiene, grooming, dressing, oral care and eating as needed. Review of Resident #17's tasks worksheet revealed her shower/bed bath schedule as following: as needed, Monday evenings, and Thursday evenings. Hair washing was documented as completed on 03/10/25 at 10:06 AM and at 11:32 PM and 03/12/25 at 1:59 PM. An observation was conducted on 03/10/25 at 9:55AM where Resident #17 was found to have greasy and unkempt hair; on a follow up observation on 03/13/25 at 1:06PM, Resident #17's hair was still greasy and itching her head. During an interview on 03/13/25 at 1:28 PM, when asked the last time Resident #17's had been washed, Staff I, Certified Nursing Assistant (CNA) stated Monday night by the afternoon shift. When asked how Resident #17's hair looked to Staff I, she stated, It looks greasy. Staff I stated her hair always looks greasy due to the type of hair she had. Staff I agreed it looked unclean and dirty and stated it should be washed more frequently than what was scheduled. 25404 3) Review of the record revealed Resident #55 was admitted to the facility on [DATE]. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] lacked a Brief Interview for Mental Status (BIMS) score as the resident was rarely or never understood. This same MDS also documented the resident was dependent upon staff for all Activities of Daily Living (ADLs). Review of the care plan last revised on 03/23/21 documented Resident #55 was incontinent of urine with a goal to maintain the resident in a clean, dry, and dignified state. An intervention included to provide incontinence care as needed. On 03/12/25 at 9:44 AM, Resident #55 was observed lying back in a padded high back wheelchair in the 400 Pod, (the common area for the residents in those rooms, where meals and activities take place). Resident #55 was continuously observed on 03/12/25 from 9:44 AM until approximately 12:30 PM. Then from approximately 1:00 PM at which time staff were finishing up assisting residents with the lunch meal, until the end of the day shift at 3:30 PM. At 2:13 PM, Staff K, Certified Nursing Assistant (CNA), started to wheel the resident to her room, but then turned her back around and returned her to the table in the Pod. At no point during the day did any staff take Resident #55 out of the Pod to check her for incontinence, or the need to be cleaned and changed. (continued on next page)

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	105755	A. Building B. Wing	03/13/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/12/25 at 3:34 PM, upon finishing her shift, when asked if Resident #55 was still in bed or was she up upon her arrival that morning, Staff K, CNA, stated she was already up in her chair. When asked at what time she had last checked to see if the resident was clean and dry, the CNA stated at about 9:30 AM. During an observation and interview on 03/12/25 at 3:44 PM, when asked about the routine for Resident #55, Staff L, evening shift CNA, stated the resident was often in bed upon her arrival at 3:30 PM. Upon removal of the resident's adult brief, Resident #55 was soiled with both urine and a large bowel movement. There was a very strong odor that made the surveyor's eyes sting, as if the resident had needed to be changed for some time. Staff L agreed with the findings. 4) Review of the record revealed Resident #79 was admitted to the facility on [DATE]. Review of the Annual MDS assessment dated [DATE] revealed the resident was severely cognitively impaired as evidenced by a BIMS score of 0, on a 0 to 15 scale. This MDS also documented the resident was dependent on staff for all ADLs. Review of a care plan initiated on 01/23/24 documented Resident #79 was incontinent of urine with a goal to maintain the resident in a clean, dry, and dignified state. Another care plan initiated on 06/29/23 documented Resident #79 was at risk for alteration in skin integrity related to impaired mobility and fragile skin. An intervention on this care plan documented staff were to provide incontinence care as per policy. On 03/12/25 at 9:52 AM, Resident #79 was observed in the 400 Pod, lying back in her specialty recliner chair. The resident was continuously observed on 03/12/25 from 9:52 AM until approximately 12:30 PM. Then from approximately 1:00 PM at which time staff were finishing up assisting residents with the lunch meal, until the end of the day shift at 3:30 PM. At no point during the day did any staff take Resident #55 out of the Pod to check her for incontinence, or the need to be cleaned and changed. During the continued interview on 03/12/25 that began at 3:34 PM, when asked when Resident #79 had been last checked for incontinence, Staff K, CNA stated she had gotten the resident up after breakfast and had not checked her since. During an interview on 03/12/25 at 4:01 PM, when asked the resident's routine, Staff L, evening CNA stated Resident #79 eats all her meals in the Pod. The CNA further explained that she checks her throughout her shift and changes her whenever she is wet or soiled. Staff L stated she would expect the day CNA to check the resident before she leaves for the day. During an observation on 03/12/25 at 4:08 PM, upon transferring Resident #79 from her chair onto the bed, the resident stated, That's heaven. Upon taking off the resident's pants, the adult brief was noted to be saturated, as the absorbent part of the brief was gelled up and heavy. Upon removal of the adult brief, there was a strong urine odor. The resident's buttock was bright red and obviously wet. (continued on next page)

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	105755	A. Building B. Wing	03/13/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/12/25 at approximately 4:15 PM, when asked her expectations from the CNAs regarding incontinence care, Staff M, Licensed Practical Nurse (LPN) stated she expects the CNAs to check their residents every two hours to see if they needed to be cleaned and changed. The LPN further volunteered, if they don't keep the residents clean and dry it will make more work for us because their skin will break down. When told both Resident #55 and Resident #79 had not been removed from the common area to be checked for incontinence or changed all day, the LPN stated she had not noticed. During an observation of Resident #79's buttock at that time, the LPN stated, I'm going to have to get something for that, referring to the reddened skin. Review of the physician orders revealed a new order dated 03/12/25 for nursing to apply triad (a barrier cream) to the resident's reddened buttocks, every shift for 14 Days. 38893 5). Record review revealed that Resident #80 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, with a reference date of 12/28/24, documented Resident #80 had a BIMS score of 07, indicating the resident had a 'severe' cognitive impairment. The assessment documented that Resident #80 required substantial/maximal assistance for personal hygiene. The MDS documented that Resident #80 was 'occasionally incontinent' of urine and 'frequently incontinent' of bowel. Resident #80's diagnoses at the time of the assessment included: Non-Alzheimer's Dementia, Malnutrition, Depression, Injury of head, Vitamin D deficiency, Nonrheumatic aortic stenosis, Sarcopenia, Cognitive communication deficit, Insomnia, and Lower back pain. Resident #80's care plan for ADLs, dated 12/23/24, documented, ADL Self-care deficit related to disease process (dementia), physical limitations. Date Initiated: 12/23/2024. The goal of the care plan was documented as, Will be clean, dressed, and well groomed daily to promote dignity and psychosocial wellbeing. Date Initiated: 12/23/2024 Target date 01/09/25. Interventions to the care plan included: o Assist with daily hygiene, grooming, nail care, dressing, oral care and eating as needed Date Initiated: 12/23/2024 Record review revealed Resident #80's ADL Task Worksheet documented shower days as Tuesday and Friday evenings, and the resident was showered according to the schedule. During an interview, on 03/10/25 at 12:24 PM, with Resident #80's family member, she stated that the underside of the resident's nails were dirty. The resident turned over her left hand and showed that there was an accumulation of residue/debris under the nails. Resident #80's family member stated that she used to be a nurse and normally would actually smell to determine what was under the resident's nails, however had not done so as of the time of the interview. During a follow up interview on 3/10/25 at 1:31 PM, Resident #80's daughter reported to the surveyor, It was feces in her nails. (continued on next page)

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	105755	A. Building B. Wing	03/13/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of lunch served to the residents in the common area of the pod, on 03/12/25 at 12:46 PM, Resident #80's nails appeared to be dirty with debris/residue that was not identified. It was determined that Resident #80 was not interveiwable based on the resident not providing appropriated answers to simple questions. During an interview, on 03/13/25 at 9:28 AM, with Staff R, CNA, when asked about providing ADL care to Resident #80, Staff R replied, 11-7 gets her up and I do follow up, I take care of her and change her and do her ADLs for her. When asked about providing care to Resident #80's nails, Staff R replied, Sometimes Activities does nail polish for her. When I toilet her, I get wet paper and go under her nails one by one. When asked about the observation of the resident's nails being dirty during the lunch observation on 03/12/25 at 12:46 PM, Staff R did not provide a response.

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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** 52127 Based on observation, record review, policy review and interview, the facility failed to ensure appropriate care and services for 3 of 28 sampled residents, as evidenced by, the failure to initiate interventions for proper positioning for Resident #95, failure to implement a brace to prevent edema and contractures for Resident #11; and failure to implement interventions in response to low blood sugar levels as per physician orders for Resident #18. The findings included: 1) Observations on 03/11/25 at 12:33 PM, 03/12/25 at 11:01 AM, and 03/12/25 at 12:33 PM revealed that Resident # 95 was positioned in a high back wheelchair with the leg rests fully elevated and a footbox over the leg rests. Resident #95 had his knees fully bent and his head and trunk were halfway down on the backrest of the wheelchair. An observation on 03/12/25 at 12:59 PM revealed two staff members lifting Resident #95 up by using the mechanical lift sling that was under him, to reposition him upright in the wheelchair prior to feeding him lunch. The resident's head was supported correctly at the top of the backrest and his trunk was against the back rest, but his knees were still bent. During an interview on 03/13/25 at 8:53 AM, Staff G, Admissions Coordinator was feeding Resident #95 and was asked if she thinks Resident # 95 looks comfortable in the wheelchair to which she responded Yes, they just elevated him a little higher. When she asked the resident if he wants to sit up, he responded by nodding his head and verbalizing uh huh. Staff G requested help from Staff F, Licensed Practical Nurse (LPN) who raised the back of the wheelchair which caused Resident #95 to slide further down in the wheelchair. Staff F then stated that Resident # 95 is always uncomfortable in the wheelchair and that she verbally advised the Director of Rehabilitation about a month ago that Resident # 95 was sliding down in his wheelchair and not sitting in it correctly. During an interview on 03/13/25 at 10:10 AM, the Director of Rehabilitation confirmed that she was made aware of the positioning concerns of Resident #95 a few weeks ago and they are looking into it. Review of the record revealed that Resident #95 was discharged from Physical Therapy on 10/24/24 with a fixed left knee contracture and the resident demonstrated better positioning and comfort with the high back wheelchair provided. 2) Record review revealed that Resident #11 was on a Functional Maintenance Program (FMP) signed by Staff D, Occupational Therapist (OT) to wear a left-hand resting splint at the beginning of each shift and to doff (remove) it at end of morning shift dated 03/07/25. It went on to state that staff were educated on wear and care of splint and that the splint is needed to reduce swelling and pain of Resident #11's left hand. The FMP also noted that Staff were educated to put Resident #11's fingers between wedges and (1) put on thumb side first, (2) straps over knuckles, (3) straps over forearm. Review of medical orders revealed that Occupational Therapy was discharged on [DATE]. (continued on next page)

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	105755	A. Building B. Wing	03/13/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 03/10/25 revealed that the left-hand splint was not on Resident #11's hand but instead it was on his lap while he was in his wheelchair outside of his room at 10:05 AM and on a table in front of him while he was in Activities at 10:58 AM. An observation on 03/11/25 at 10:16 AM revealed that Resident #11 had the hand splint on incorrectly, as his fingers were bent into a fisted position and not located in between the wedges that support them, and the straps were only applied over his forearm and not over his thumb or knuckles. When Staff B, Certified Nursing Assistant (CNA) was asked, what do you know about Resident # 11's hand splint? on 03/12/25 at 10:56 AM, she replied that the hand splint is on when Resident #11 is out of bed. When Staff B was asked Where do you document information about the left-hand splint? She stated that we document on Kardex, and it is a new hand splint. During an interview on 03/12/25 at 1:19 PM, the Director of Nursing (DON) stated that they do not have a written policy for communication between the therapy department and nursing. The DON explained that the therapy department Inservice's staff and provides an FMP when a resident is assigned adaptive equipment, and the Nurse Unit Manager adds the information to the tasks/Kardex system Record review dated 03/13/25 in the facilities Kardex system disclosed that the hand splint was not listed or documented in the records for Resident #11. 38893 3). The facility's policy titled, 'Obtaining a Fingerstick Glucose Level', with a reference date of January 2020, did not provide procedures for following physician's orders for implementing and documenting interventions in response to low blood sugar levels. Record review revealed that Resident #18 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Medicare 5-day MDS, dated [DATE], documented Resident #18 had a BIMS score of 03, indicating a 'severe' cognitive impairment. Resident #18's diagnoses at the time of the assessment included Diabetes Mellitus and long-term use of insulin. Resident #18's orders dated 01/29/25, included: Admelog Injection Solution 100 UNIT/ML (Insulin Lispro) - Inject as per sliding scale: if 0 - 139 = 0 unit - If blood glucose is below 75 give orange juice or glucose pen and recheck. Resident #18's care plan for diabetes and the use of insulin, documented, Endocrine System related to; Insulin Dependent Diabetes. Date Initiated: 07/06/2023. The goal of the care plan was documented as, To minimize/be free of complications related disease process Date Initiated: 07/06/2023 Interventions to the care plan included: o Administer medication per physician orders Date Initiated: 07/06/2023 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105755	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Report symptoms of hyperglycemia: excessive thirst/urination, hunger, weakness, N/V, acetone breath Date Initiated: 07/06/2023 o Report symptoms of hypoglycemia: weakness, pallor, diaphoresis, vision changes, change in consciousness. Date Initiated: 07/06/2023 Review of Resident #18's Medication Administration Record (MAR), on 03/11/25 at approximately 11:00 AM, revealed the following: On 03/12/25 at 7:26 AM, Resident #18's blood glucose level was documented as 68 as documented by Staff A, LPN (Licensed Practical Nurse). On 03/11/25 at 8:55 AM, Resident #18's blood glucose level was documented at 68 as documented by Staff A, LPN. On 03/07/25 at 7:58 AM, Resident #18's blood glucose level was documented as 68 as documented by Staff A, LPN. On 03/03/25 at 8:26 AM, Resident #18's blood glucose level was documented as 68 as documented by Staff A, LPN. On 03/02/25 at 8:25 AM, Resident #18's blood glucose level was documented as 68 as documented by Staff A, LPN. Further review of the resident's electronic health record revealed no documentation of interventions to the resident's blood glucose readings being below 75 During an observation of the unit pantry on the Turtle Bay Unit (100, 200, and 300 pods), on 03/12/25 at 10:16 AM, accompanied by the ADON (Assistant Director of Nursing), it was noted that there was only one container of thickened orange juice in the cabinet and no additional juices in the pantry. The ADON stated that the pantry is stocked with juices and snacks at 10:00 AM, 2:00 PM and 6:00 PM. The ADON further stated that there is supposed to be water and juice on a cart on each unit. During a unit by unit tour of the 100, 200 and 300 pods, it was noted that the only fluids readily available on the units were coolers of water with no indication that there was orange juice available as an intervention for low blood glucose. During an interview, on 03/12/25 at 11:19 AM, with Staff A, LPN, when asked about interventions in response to Resident #18's low blood glucose levels, Staff A replied, we offer him a snack. In the morning, it's usually when it is lowest when I check around 7:30 - 7:45 AM and that is right before breakfast. I will give him some orange juice to hold him until breakfast. When asked about documenting the interventions that were implemented, Staff A replied, It doesn't show where I should document, it just says 'no coverage given (referring to documenting in the resident's electronic health record). (continued on next page)

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	105755	A. Building B. Wing	03/13/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked about checking blood glucose levels after implementing the interventions, Staff A replied, I wait until lunch and then check it again after lunch. Staff A further confirmed that she gives snack or orange juice and does not check Resident #18's blood glucose levels again until lunch time.

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	105755	A. Building B. Wing	03/13/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50895 Based on observations, an interview, and record reviews, the facility failed to monitor the effectiveness of interventions for nutrition for 1 of 18 sampled residents (Resident #26) reviewed for nutrition. The findings included: Record review revealed Resident #26 was admitted to the facility on [DATE]. His diagnoses included Dementia, and Dysphagia (swallowing difficulty), following Cerebrovascular Disease. On 12/17/19, Resident #26 weighed 183 lbs (pounds). On 03/01/25, Resident #26 weighed 149.4 lbs. His BMI was 20.8, which was considered underweight for advanced age. Resident #26 was at risk for malnutrition per the nutrition care plan last revised on 02/25/25. Resident #26 was also at increased risk for aspiration. His prescribed diet order effective since 03/06/25 was for the enhanced diet, with pureed texture, and moderately thick fluids. On 03/10/25 at 03:26 PM, Resident #26 was observed seated at his dining location in the 200s POD. The POD is a shared community space for meals and other activities. He had signs and symptoms of malnutrition. He had visible muscle wasting to his clavicles. During the dinner meal on 03/10/25 at 5:33 PM, Resident #26 consumed 90% of his meal before the staff finished serving the other residents in the room. The other 2 residents at his table still had 95% of their food in front of them. On 03/11/25 at 12:05 PM, Resident #26 was served his lunch meal in the 200s POD. At 12:11 PM Resident #26 completed eating all of the food on his meal plate and he ate the vanilla pudding. At 12:14 Resident #26 continued to eat from the pudding cup. With his spoon he scraped and scraped the interior walls of the cup for more pudding. He was not offered more food. Resident #26 picked up the cup of nectar thickened juice and he drank some. Then he drank some nectar thickened water. He alternated drinking the fluids and completed one hundred percent of the juice and approximately forty-five percent of his water. On 03/11/25 at 12:20 PM, Staff S finished feeding the resident who sat next to Resident #26 during the lunch meal. She removed both residents from the table and positioned them approximately three feet away from table, and close to the back wall. She placed Resident #26 in the reclining position. Then, Staff S cleared away the dishware from the table. The remaining fifty-five percent of Resident #26's nectar thickened water was removed. The resident watched the nurse's movements as she took the dishware and his tray and placed it back into the cart. During a lunch observation on 03/12/25, at 12:12 PM, Resident #26 ate all the food served on his meal plate in seven minutes. (continued on next page)

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	105755	A. Building B. Wing	03/13/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of the lunch meal on 03/13/25 at 12:01 PM, Resident #26 sat in his wheelchair and layed forward on the table. He was asleep. An activities personnel gently woke up the resident and served him the lunch meal. At 12:02 PM Resident #26 began to drink his fluids. Then he ate the food and completed the meal at 12:17 PM. One hundred percent of the food on the meal plate was consumed. At 12:22 PM, the ADON handed the cup of pudding to the resident. The Resident completed eating the 4 oz vanilla pudding. Staff E (a nurse supervisor), walked by the table and said to the resident Good job. Resident #26 scraped and scraped his spoon on the interior walls of the cup. During an interview on 03/13/25 at 12:10 PM, the surveyor asked Staff E what it meant to her when she saw Resident #26 scrape and scrape his spoon on the inside walls of the pudding cup. She said, Maybe he needs double portions. The Nurse Supervisor said that she will make the RD (Registered Dietitian) aware. A review of Resident #26's meal intakes from 02/28/25 - 03/12/25 revealed that thirty-seven out of thirty-nine meals showed 100% of the meal was consumed. Two out of thirty-nine meals showed 75% consumption.

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	105755	A. Building B. Wing	03/13/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50895 Based on observations, policy review, record reviews, and interviews, the facility failed to have a doctor's order for the administration of enteral feeding, also known as tube feeding, for 1 of 1 sampled resident (Resident #50), reviewed for dependence on enteral feeding to meet their needs for nutrition. The findings included: Review of the facility's Nursing policy on the Services Procedure for Nutrition services on Feeding Systems, dated 10/2019, documented Nursing must confirm that a physician's order is in place for enteral feeding. Record review revealed that Resident #50 was admitted to the facility on [DATE]. Resident #50 went out to the Hospital emergency roiagnom on [DATE] for replacement of the PEG tube (a percutaneous endoscopic gastrostomy tube, is a thin flexible tube inserted through the skin into the stomach to provide nutrition and medication), and she returned on the same day. Her diagnoses included Dysphagia (swallowing problem) following Unspecified Cerebrovascular Disease, Cerebral Infarction, Unspecified Dementia, Unspecified Severity with Other Behavioral Disturbance, and Gastrostomy Status. According to a follow-up note in the electronic medical record system on 02/25/25, the RD (Registered Dietitian) wrote: Resident #50 remains PEG tube dependent for her nutrition and hydration. A Doctor's diet order for nothing by mouth was last revised on 11/04/21. There was no active order for an enteral formula to be administered to provide nutrition by the PEG tube. A review of the focus of Resident #50's care plan last revised on 09/17/24 documented that this resident's risk for malnutrition was related to dependence on a Peg tube to meet nutrition needs. An intervention listed on 04/11/22 specified to provide Tube Feed and Flushes as ordered. In a review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that Resident #50 had severe cognitive impairment. It also revealed that Resident #50 received greater than 51% of nutrition via tube feeding. A review of the Medication Administration Records and the Treatment Administration Records for March 2025, showed no documentation that a nutrition formula was administered. During observations on 03/10/25 at 05:17 PM, 03/11/25 at 8:42 AM, and 03/12/25 at 9:47 AM, Resident #50 was lying down in her bed with her eyes closed. The enteral formula, Jevity 1.5 Cal, was being administered at 47 ml/hr. The Jevity nutrition formula and a clear plastic bag of water, was hanging from the metal pole of the pump delivery system. (continued on next page)

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	105755	A. Building B. Wing	03/13/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/25 at 3:29 PM, the Registered Nurse Supervisor, Staff E, was asked how she knew how much formula to administer to the resident. She answered that she starts the pump at 2:00 pm and administers Jevity at 47 ml/hr until 10 am the next morning. She said that there must be an order in the electronic medical records system. When Staff E was asked how she knew this information agreed with the physician's order, she looked at the medical records and was unable to locate an order for the nutrition formula. Staff E responded, I usually don't write a note for that, it's a routine order, so I just know to start it at 2 pm and to end it at 10 am. During an interview on 03/12/25 at 3:35 PM, the Assistant Director of Nursing confirmed that there was no current order specifying the order for a tube feeding formula. She said it would be added in right away. On 03/12/25 at 3:44 PM an order for the administration of Jevity 1.5 was entered.

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	105755	A. Building B. Wing	03/13/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on observation, record review, and interview, the facility failed to ensure non-pharmacological interventions to reduce pain during personal care for 1 of 4 sampled residents, Resident #32, who was observed during personal care. The findings included: Review of the record revealed Resident #32 was admitted to the facility on [DATE], after having sustained a fall at home with a subsequent left hip fracture. The record documented the lack of surgery for the hip with routine healing expected. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 3, on a 0 to 10 scale, indicating severe cognitive impairment. This MDS also documented the resident was dependent upon staff for any care involving her lower extremities. Review of the care plan dated 02/19/25 documented Resident #32 had a functional mobility deficit as evidenced by severe pain to her left hip, secondary to the left hip fracture. Another care plan initiated on 02/19/25 documented the resident was at risk for pain related to the hip fracture. Neither of these care plans documented any instructions related to how to turn the resident during care to help reduce pain from the necessary turning during personal care. During an interview on 03/10/25 at 12:22 PM, the family member of Resident #32 confirmed they were not going to do any surgery for the hip fracture because of the resident's age. The family member stated she was happy with the care, but further stated [Resident #32] was in excruciating pain whenever she was moved for care. The family member voiced [Resident #32] was on pain medications, but did not want her on any increased or additional medications. Record review revealed the resident was receiving Tramadol (a pain medication) routinely, three times daily. An observation of personal care for Resident #32 was made on 03/12/25 at 3:00 PM, by Staff K, Certified Nursing Assistant (CNA), and assisted by Staff Q, CNA, for positioning assistance. The CNAs turned Resident #32 to her right side to provide personal care to her back side, crossing her left leg over her right. The resident immediately started moaning and crying out in pain. After a few moments of care, Resident #32 yelled out No mas (the Spanish words for No more). The CNAs verbally consoled the resident, stating it would be just a few more minutes, but the resident continued to cry out Oh . oh my . no mas. After the provision of care, when asked if it always hurts when she is turned over for care, Resident #32 stated, Of course. During an interview after the care at 3:25 PM, when asked about Resident #32's pain during the care, Staff K, CNA, stated, She does yell out sometimes and then you have to stop. The CNA agreed she did not stop during the care that she had just provided. During an interview on 03/12/25 at 3:42 PM, when asked if there were any positioning techniques that could reduce some of the pain during care for Resident #32, Staff N, Physical Therapist (PT) stated the resident was not on any type of precautions except non-weight bearing to the left leg. The PT further stated that placing pillows between the resident's legs during care would help with the pain. (continued on next page)

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	105755	A. Building B. Wing	03/13/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/13/25 at 11:29 AM, when asked about the resident's pain while turning during personal care, Staff M, Licensed Practical Nurse (LPN) agreed Resident #32 was in pain during care. When asked if she was aware of any measure to reduce the pain, for example placing pillows between the resident's legs as suggested by therapy, the LPN stated, No. I don't know what therapy is doing with her.

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	105755	A. Building B. Wing	03/13/2025

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50895 Based on observations, interview, policy, and record reviews, the facility failed to provide food in a form to meet the individual needs of residents for 2 of 4 sampled residents (Resident #43, Resident #57) reviewed for pureed texture diets. This had the potential to affect 28 residents who were on pureed texture diets. The findings included: A review of the facility's policy for pureed diets, documented that it was used for patients with swallowing and chewing difficulties. It specified that all foods are smooth in texture and free from whole, minced or ground pieces. The policy stated that the pureed diet follows the recommendations for the Level 1 Dysphagia Pureed Diet of the National Dysphagia Diet. 1. During an observation on 03/10/25 at 5:37 PM, Resident #43 was served his dinner. His meal ticket said that he was on a Puree texture diet. The pureed bread was lumpy. Photographic evidence obtained. Record review revealed Resident #43 was admitted to the facility on [DATE]. His diagnoses included Sarcopenia, Dementia, and Oral Dysphagia (a swallowing problem). His prescribed diet order since 01/10/25 was for an enhanced diet, with a pureed texture, and thin fluids. According to the Minimum Data Set quarterly assessment dated [DATE], Resident #43 had severe cognitive impairment. Resident #43's care plan last revised on 01/10/25, had a focused care plan on nutrition that was related to dysphagia and his risk for malnutrition. 2. During an observation on 03/10/25 at 5:40 PM, Resident #57 was served her dinner. Her meal ticket documented that she was on a Pureed texture diet. The pureed meat had small pieces in it. It was not a uniform texture. In addition, the pureed bread was lumpy. Photographic evidence obtained. Record review revealed that Resident #57 was admitted to the facility on [DATE]. She has received hospice services since 09/22/23. Her diagnoses included Alzheimer's disease and Dementia. According to the Minimum Data Set quarterly assessment dated [DATE], Resident #57 had severe cognitive impairment. Her prescribed diet order initiated on 10/23/23 was for an enhanced diet, with a pureed texture, and thin fluids. Resident #57's care plan last revised on 02/07/2025 had a focused care plan for malnutrition that was related to her history of Dysphagia. During an interview on 03/10/25 at 05:45 PM, the surveyor notified the Senior Dining Services Manager about a concern that the pureed foods were not a smooth, homogenous texture. The surveyor requested a pureed dinner plate. When asked what each of the pureed foods on the plate was, the Senior Dining Services Manager identified pureed ham, pureed mixed vegetables, mashed potato, and pureed bread. The surveyor and the Senior Dining Services Manager tasted the food items. The pureed bread had lumps in it, and the pureed ham was not smooth. The Senior Dining Services Manager agreed with the findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on policy review, observation, record review, and interview, the facility failed to follow an infection control program to help prevent infections for 5 of 7 sampled residents as evidenced by the failure to ensure physician orders for Enhanced Barrier Precautions (EBP) for Resident #2, #32, and #46, failure to properly maintain the indwelling urinary catheter for Resident #32, and failure to ensure proper hand hygiene and don gloves during eye drop administration for Resident #87. The facility also failed to maintain the laundry area in a manner to prevent the spread of infection. The findings included: 1) Review of the record revealed Resident #2 and #46 had pressure ulcers, and Resident #32 had an indwelling urinary catheter. During an interview on 03/13/25 at 2:33 PM, when asked what was expected when a resident needed to be placed on EBP, the Director of Nursing (DON) stated there should be a physician order, signaled and personal protective equipment (PPE) at the resident's room, and documentation in the care plans. When asked about Residents #2, #46, and #32, the DON agreed they were to be on Enhanced Barrier Precautions due to their wounds and the urinary catheter. When asked to locate and provide a current physician order for the EBP, the DON and Assistant DON (ADON) were unable to locate any current orders for the EBP for these three residents. When asked who was responsible for obtaining and entering these orders, the ADON stated the Unit Managers would usually enter the orders. 2) Review of the policy Urinary Catheter Care dated July 2015, documented, in part, Key Procedural Points . 8. Be sure the catheter tubing and drainage bag are kept off the floor. 11. Check to see that the catheter remains secured with a leg strap, if applicable, to reduce friction and movement at the insertion site. Review of the policy Urinary Leg Drainage Bags dated December 2018 documented staff were to wipe the catheter and drainage bag junction with alcohol upon removal or application of a new device. Review of the record revealed Resident #32 was admitted to the facility on [DATE], after having sustained a fall at home with a subsequent left hip fracture. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 3, on a 0 to 10 scale, indicating severe cognitive impairment. This MDS also documented the resident had an indwelling urinary catheter. During an observation on 03/10/25 at 11:10 AM, the urine in the drainage tubing was amber in color with sediment noted. Photographic evidence obtained. Record review revealed Resident #32 had a Urinary Tract Infection (UTI) as evidenced by a urinalysis collected on 03/11/25. During an observation on 03/12/25 at 10:49 AM, Resident #32 was lying in bed. The urinary catheter drainage bag was lying directly on the resident's fall mat, that was visibly stained and dirty. Shortly after leaving the room, Staff K, Certified Nursing Assistant (CNA) went into the room. The CNA picked up the urinary catheter bag and hung it on the bed frame, left the room, and failed to report her findings to the nurse who was in the 400 Pod (common area) at her medication cart. (continued on next page)

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	105755	A. Building B. Wing	03/13/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of personal care on 03/12/25 at 2:45 PM, by Staff K, CNA and Staff Q, CNA, the urinary drainage bag was noted detached from the urinary catheter. The ADON, who was present during the observation, asked the staff to obtain a new drainage bag. Personal care was provided by the two CNA, with the catheter detached from the drainage bag during the entire procedure, being moved by the CNAs during the care, and lying on the bed at times during the care. Upon finishing the care, Staff K was told by the ADON to connect the new drainage bag. The CNA hooked up the new bag without wiping with an alcohol wipe. While hooking the new bag to the indwelling catheter, Staff K, CNA, pulled the catheter straight up, pulling it taunt, and Resident #32 stated, cuidado, which is Spanish for be careful. After completion of care, when asked where it hurt during care, the resident stated in Spanish, below, and pointed to her private area. 3) A medication pass observation for Resident #87 was completed on 03/12/25 beginning at 9:52 AM, with Staff F, Licensed Practical Nurse (LPN). The LPN prepared an Artificial Tears eye drop for the resident. The LPN failed to do any type of hand hygiene prior to administration of the eye drops, failed to wear gloves during the administration, and failed to do any type of hand hygiene after administration. During an interview on 03/12/25 at 12:26 PM, when asked her process for wearing gloves during the eye drop administration, Staff F, LPN stated, It depends. Sometimes I wear gloves and sometimes I don't. When asked if she knew the policy related to gloves with eye drop administration, and the LPN stated, No. 38893 4). During a tour of the Laundry, on 03/13/25 at 12:27 PM, accompanied by the Environmental Services Director, the following were noted: a. Inside the sorting room, there was a hand washing sink that did not have appropriate signage to instruct staff to perform hand hygiene. b. The base of the pedestal that supported the eye wash station next to the hand washing sink was rusted and corroded. c. There was an accumulation of residue and debris in the basin of hand washing sink in the washing area and the sink did not have signage to instruct staff to perform hand hygiene. At the time of the observation, there were no other means for staff to perform hand hygiene (e.g. hand sanitizer). When Staff T, Housekeeping Aide, turned the water to the sink, debris started floating in the basin. d. There was debris that was melted to the interior of the drum of dryer #1 (the dryer on the far left). The Environmental Services Director stated that the dryer had been in that condition for the last year that she had been in the position. e. The rubber gaskets around the tops of the baskets that were used to transport laundered items was noted to be worn. At the conclusion of the tour, the Environmental Services Director acknowledged understanding the concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105755	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Nursing & Rehab Center	3600 Old Boynton Road Boynton Beach, FL 33436

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Photographic evidence obtained of all findings during the tour of the Laundry.