STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105837	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boynton Beach Rehabilitation Center	9600 Lawrence Rd 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, interview and record review, the facility failed to ensure resident rights for 1 of 2 sampled residents (Resident #96), as evidenced by the failure to provide showers in a dignified manner and access to the call bell.The findings included:Review of the policy titled, Procedural Guidelines, Shower, updated 09/2023, documented, in part, For a shower, place shower chair in shower for support.Review of records revealed that Resident #96 was admitted to the facility on [DATE] with diagnoses that include Hemiplegia following Cerebral Infarction affecting Left Non-Dominant side and Right Below Knee Amputation (BKA). Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #96 had a Brief Interview for Mental Status (BIMS) score of 12 on a 0-15 scale indicating moderate cognitive impairment. The current care plan initiated 01/27/26 revealed Resident #96 required Substantial/ Maximal assistance of one for bathing.During an initial interview on 03/24/26 at 10:05 AM, Resident #96 stated that his call bell does not always work because the nurse comes in and takes it out of the wall. Resident #96 was asked why he pushes the call bell, and he stated that he pushes it when he is in pain, cold and wet, and when he is constipated. Resident #96's significant other who visits him daily stated that she has seen the call bell pulled out the wall when she has arrived and when they ask the staff about it, they say someone must have pulled it out. Resident #96 went on to state that when he gets showers twice a week, they put the whole wheelchair in the shower, and he does not use a shower chair, and that the wheelchair is soaking wet.Resident #96 was sitting in his wheelchair with his right leg (BKA) on the pad of the elevated leg rest and his left foot on the footrest of the wheelchair. He had a cushion on the seat of the wheelchair and a cushion on the backrest of the wheelchair that had lateral trunk supports. Resident #96 stated that therapy provided him with cushions since he was leaning to the side and added a padded tray on the left armrest for his left paralyzed arm to rest on.An interview was conducted on 03/25/26 at 3:00PM with Staff C, Certified Nursing Assistant (CNA), who has worked at the facility for 9 years. When Staff C was asked if she assists Resident # 96 with showers she stated she gives him showers during the 3-11 shift on Mondays and Thursdays. She was asked if he sits in a shower chair or a wheelchair and Staff C stated that she gives him a shower while positioned in his wheelchair with the sling under him for the mechanical lift but removes the back cushion and seat cushion so they do not get wet. When asked why she does not have Resident #96 sit in a shower chair she stated it is not safe for him since he moves in the chair and slides down. We went to the shower room and she showed the surveyor the 3 shower chairs and stated that one is too wide and too low for him since he leans to the side, the other two do not have enough support and that he slides down in them and it is not safe to give him a shower while sitting in it. She stated that they transfer him back to the bed using the mechanical lift and remove the sling and make sure he is dried and then dry the wheelchair and use a pad on it to help it dry out. Staff C was asked if the nurse knows that she gives Resident #96 a shower in the wheelchair instead of the shower chair she stated that the nurse's know. She was asked if there are other residents who are showered in their wheelchairs, she stated no, just Resident #96. An interview was conducted on 03/25/26 at 3:30 PM (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
	105837	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boynton Beach Rehabilitation Center	9600 Lawrence Rd 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with Staff D, Licensed Practical Nurse (LPN) who has worked at the facility for 4 years and was familiar with Resident #96. She was asked if she knows who gets showers during her shift and she stated yes, they have a shower schedule, and I see them go past with the CNA to the shower room. She was then asked if she knew that Resident #96 was getting his showers while in his wheelchair and she stated that she did not give the CNA permission to use his wheelchair for showers, but the CNA's told her it is safer than using the shower chair. Staff D was then asked if she communicated that CNA's feel it is unsafe to shower Resident #96 in the shower chair and use his wheelchair to anyone else in the facility like the Assistant Director of Nursing (ADON), Director of Nursing (DON) or Therapy and she stated she had not. On 03/26/26 at 7:33 AM Resident #96 was sitting up in his wheelchair in the TV room near the nurse's station. Resident #96 was asked if he was ever given a shower in one of the shower chairs and he stated he did not think he ever had a shower in anything but his wheelchair. He was then asked why he did not want to be showered in his wheelchair, and he stated because it stays wet and it is just not right. He was then asked about his call bell and if it had been working properly and he stated no, they pulled it out of the wall again last night. He was asked how he gets help when the call bell does not work and he stated that he screams for help.On 03/26/26 at 7:41 AM, the call bell in Resident #96's room that was located on the 1/4 siderail on the left side of the bed was activated and the red light on the wall did not light up. Upon further inspection, the call bell was not pushed all the way into the outlet on the wall. The Resident in the bed next to Resident #96 allowed the surveyor to test his call bell that was pushed fully into the outlet on the wall, and the red light did go on.On 03/26/26 at 7:44 AM an interview was conducted with Staff C, CNA and Staff E, LPN who were asked to test Resident #96's call bell that was located on the 1/4 siderail on the left side of the bed and when Staff E pushed the button on the call bell the red light did not go on and she stated that it was working yesterday. Then Staff E and Staff C decided to check the plug at the wall and pushed it in the wall and then it worked. Staff C and Staff E were asked why the call bell wasn't fully plugged into the outlet and Staff C stated that sometimes the cord gets coiled on the side rail and then pulls it partially out of the wall. Staff C and Staff E did not have to adjust the cord since it was not pulling or coiled and once it was pushed back into the outlet it worked. They were asked if Resident #96 pushes his call bell often and Staff E stated, yes, but only when he needs something.An interview was conducted on 03/26/2026 at 8:15 AM with Resident #96's significant other who had arrived for her daily visit and was asked about the call bell and how it was positioned when it did not work and she stated it is pulled out of the outlet just enough to look like it is plugged in but it does not work unless it is pushed all the way in and that sometimes she has found it like that in the morning when she arrives at the facility.Photographic Evidence Obtained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105837	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boynton Beach Rehabilitation Center	9600 Lawrence Rd 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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure quality of life for 1 of 5 sampled residents (Resident #108) as evidenced by the failure to assist with positioning in bed for meals.The findings included: Review of the record revealed that Resident #108 was admitted to the facility on [DATE] with diagnoses including Rheumatoid Arthritis. Review of the current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #108 required set- up assistance for eating and partial to moderate assistance for transitioning from lying to sitting in bed. The MDS also revealed that Resident #108 had a Brief Interview for Mental Status (BIMS) score of 15 on a 0-15 scale indicating the resident had intact cognition.During an initial interview on 03/24/26 at 8:10 AM, Resident #108 was asked if she was in a good position to eat her breakfast and she stated, no, but I do not want to bother anyone. Resident #108 had her bedside table over the bed with her breakfast tray on the table and the head of her bed was elevated a small amount making the tray almost level with her shoulders/mouth.An interview was conducted on 03/24/26 at 8:12 AM with Staff A, Certified Nursing Assistant (CNA) who was asked if she delivered Resident #108 her tray this morning and set it up for her and she stated, yes. Staff A was asked if she thought that Resident #108 was in a good position to eat and Staff A went over to Resident #108 and raised the back of the bed a little bit more which did not help since Resident #108 was down low in the bed, and then stated to Resident #108 you're okay, right. During further discussion between Staff A and the surveyor about having 2 people assist with lifting Resident #108 further up in the bed and then raising the head of the bed, Staff A stated that Resident #108 tends to lean to the right side when she is sitting upright in bed and that is why she does not leave her that way. When Staff A left the room, Resident #108 stated that she knew that she needed to have them to pull her up in the bed but they do not do that anymore. Staff from the admissions office and business office stopped by the room and asked Resident #108 if she needed to be repositioned and the surveyor asked them if they typically assist with repositioning residents in bed for meals and they stated they did not. They were asked to have Staff A come back into the room and at 8:20 AM Staff A came back in and the staff member from Admissions assisted Staff A with repositioning Resident #108 up in her bed. After being pulled up in bed, Staff A assisted with raising the head of the bed and the tray table to allow Resident #108 to see her food and eat and drink in a more comfortable position.On 03/25/26 at 7:59 AM, Staff B, Licensed Practical Nurse (LPN) Unit Manager was assisting Resident #108 with her tea was asked if she thought that Resident #108 was in a good position to eat, (Resident #108 was slid down in the bed and the head of the bed was only elevated a small amount and the tray was not close to the resident)and Staff B stated no, but Resident #108 tends to lean to the right when its upright. Staff B asked Resident #108 if she is in a good position to eat and she stated, no. Staff B went and got the nurse and they assisted resident up in the bed and when the surveyor stated you look better now, Resident #108 said oh, thank you so much. Resident #108 stated that if she had something to hold onto, she may be able to reposition herself when she leans to the right. Resident #108 was asked if she had ever asked for side rails and she stated she was told they were illegal. Resident #108 stated she will ask for them and when her nurse came into her room she did request 1/4 siderails and the nurse agreed to put in a request to have Resident #108 assessed for siderails.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105837	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boynton Beach Rehabilitation Center	9600 Lawrence Rd 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow up on physician ordered urine culture for 1 of 3 sampled residents for urinary tract infections (Resident #4). The findings included:Record review revealed Resident #4 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had mild cognitive impairment and required partial/moderate assistance with activities of daily living.A review of Resident #4's orders revealed an order dated 03/19/26 for a urinalysis with culture. Further review of the resident's orders revealed an order for intravenous (IV) antibiotics dated 03/19/26.A review of Resident #4's records on 03/26/26 revealed no results for the ordered urine culture on 03/19/26.An interview was conducted with the Nurse Practitioner (NP) on 03/26/26 at 10:00 AM. The NP stated she expected staff to follow up with the ordered urine culture to identify the specific organism of the infection to ensure Resident #4 was receiving the appropriate antibiotic treatment. If the culture was not able to be done, the NP stated she expected to be notified.An interview was conducted with the Director of Nursing (DON) on 03/26/26 at 12:00 PM. The DON was informed of the above.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105837	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boynton Beach Rehabilitation Center	9600 Lawrence Rd 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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, interview and record review, the facility failed to provide assistive devices for 1 of 8 sampled residents, as evidenced by failure to provide 2-handled cup to Resident #108.The findings included:Review of the policy titled, Rehabilitation Space, Equipment, & Supplies, revised on 08/2023, documented in part, 8. Resident specific equipment is issued by the treating therapist who provides instruction in the use of the equipment, and who documents the resident's response to the equipment in the medical record.Review of the record revealed that Resident #108 was admitted to the facility on [DATE] with diagnoses including Rheumatoid Arthritis. Review of Physicians' orders revealed an order dated 10/08/24 for Resident to receive 2 handled cup and scoop plate at all meals.An interview was conducted on 03/24/26 at 8:34 AM when Resident #108 was eating breakfast and had one 2 handled cup filled with orange juice and a regular coffee mug filled with tea. Resident #108 stated that it is difficult for her to drink the tea out of the coffee mug since it only has one handle and does not have a lid with a spout. Resident #108 stated that she has Rheumatoid Arthritis that makes it hard to hold things with her hands and that she has poor vision and likes the two handled cup with the lid when drinking fluids.On 03/25/26 at 7:59 AM, Resident #108 was being assisted with setting up her tray and getting tea by Staff B, Licensed Practical Nurse (LPN) unit manager who put the hot tea in the 2 handled cup that was delivered empty on her tray and the orange juice was in a standard juice cup without any handles. Resident #108 stated that it would be difficult for her to drink the orange juice out of that cup.An interview was conducted on 03/25/26 at 8:22 AM with Staff B who was asked if it was okay that Resident #108 was drinking her tea from a 2 handled cup but her orange juice was in a standard cup and she stated, no, I will ask the kitchen to send her two 2 handled cups from now on. She was then asked if the orange juice is sent from the kitchen shouldn't it be sent on her tray in a 2 handled cup and she agreed that it should be.An interview was conducted with the Culinary Manager on 03/25/26 at 8:34 AM who stated that she did not know that Resident #108 drank tea and that is why she was only sent one empty 2 handled cup. The Culinary Manager was asked if the orange juice is sent from the kitchen, why is it in a standard cup and not in a 2 handled cup and she agreed that it should have been in a 2 handled cup sent from the kitchen.Photographic Evidence Obtained.