Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95047	A. BUILDING: _____ B. WING _____	05/01/2025

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WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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N 000	INITIAL COMMENTS An unannounced Relicensure survey was conducted on through at Willowbrooke Court at St. Andrews Estates. The facility had deficiencies at the time of the survey.	N 000		
N 090 SS=D	59A-4.112(1), FAC Pharmacy Policies and Procedures (1) The nursing home licensee must adopt procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident. This Statute or Rule is not met as evidenced by: Based on record review, interview and observation, the facility failed to maintain a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, to determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for 1 of 5 sampled residents reviewed for controlled medications, Resident #4. The findings included: Review of the facility's policy titled, "Medication, Controlled Substances", with a revised date of , included in part the following: "To strive to ensure that strict management of controlled substances is maintained as evidence by special handling, storage , disposal and record keeping. When a resident receives a , the licensed nurse signs off each dose of the controlled medication given by documenting the following on the sheet and the electronic medication administration record [eMAR]."	N 090	he statement made on this Plan of Correction are not and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulation the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Immediate Corrective Action: On , resident #4 , screening completed, resident's , level was noted to be at zero. On , licensed nurses were re-educated by the Director of Nursing on the importance of ensuring all medication administrations are signed off in pharmacy log and on Medication Administration Record (MAR) in Point Click Care for accurate account of controlled medications.	

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N 090	Continued From page 1 Record review for Resident #4 revealed a most recent readmission to the facility on with diagnoses that included in part the following: Displaced Supracondylar Without Intracondylar Extension of Lower End of Right Subsequent Encounter for Closed with Routine Healing, on Same Level From Slipping Tripping and Stumbling Without Subsequent Striking Against Object Subsequent Encounter, in Left , and Around Internal Left Subsequent Encounter. The Minimum Data Set dated documented in Section C a Brief Interview of Mental Status score of 14 indicating a response. Review of the physician's orders for Resident #4 revealed an order dated for Oral Tablet 50 MG ( ) Give 1 tablet by every 6 hours as needed for , was discontinued . Review of the physician's orders for Resident #4 revealed an order dated for Oral Tablet 50 MG ( ) Give 1 tablet by every 8 hours as needed for moderate ( ). Review of Controlled Medication Utilization Record for Resident #4 for 50mg tablet give 1 tablet by every 8 hours as needed for , documented in part the following: On at 1:30 AM, 1 tablet was removed. On at 7:00 AM, 1 tablet was removed. Review of the Medication Administration Record for Resident #4 for the month of , revealed no documentation of having been administered on at 1:30 AM or on at 7:00 AM.	N 090	Identification of other residents potentially affected: Quality review audit of completed. Current residents have the potential to be affected; resident #4 was not affected. Measures: On , licensed nurses were re-educated by the Director of Nursing on the importance of ensuring all medications administration are signed off in pharmacy log and on Medication Administration Record (MAR) in Point Click Care for accurate account of controlled medications. In-services/training will be completed for newly hired licensed nurses. Monitoring: The Director of Nursing/nursing team will complete daily audits during clinical meeting for 4 weeks and then weekly x 3 months to ensure records are in order and that an account of all controlled drugs is maintained and reconciled. Director of Nursing will report the findings to the Quality Assurance Performance Improvement Committee Monthly X 4 months or until the committee determines substantial compliance.	

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N 090	Continued From page 2 An interview was conducted on at 11:00 AM with Staff C, Registered Nurse (RN), who stated she has worked at the facility for 5 years. When asked about the process of removing and administering controlled medications, she stated they remove the medication, mark it on the Control Sheet, and sign it off on the MAR once it is given to the resident. An interview was conducted on at 11:15 AM with Staff A, Licensed Practical Nurse (LPN), who stated she has worked at the facility for 3 years. When asked about the process for removing and administering controlled medications, she stated they remove the medication, mark it on the Control Sheet, and sign it off on the MAR once it is given to the resident. Class III	N 090		
N 096 SS=D	59A-4.112(7), FAC Drug Disposal (7) All controlled substances must be disposed of as required by the Department of Health, Rule 64B16-28.303, F.A.C. All non-controlled substances may be destroyed in accordance with the facility's policies and procedures. Records of the disposition of all substances shall be maintained in sufficient detail to enable an accurate reconciliation and a copy of the disposition must be filed in the resident's record or maintained electronically in a readily accessible format. This Statute or Rule is not met as evidenced by: Based on observations, interview and record	N 096	The statement made on this Plan of	

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N 096	Continued From page 3 review, the facility failed to secure 1 of 3 medication carts, failed to secure 1 of 2 treatment carts, and failed to secure and properly dispose of medications (meds) during 1 of 4 medication administration observations. The findings included: Review of the facility's policy, titled, "Storage and Expiration Dating of Medications and Biologicals", with a revised date of , included in part, the following: "Facility should ensure medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators / freezers of sufficient size to prevent crowding. Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. Facility should ensure the medications and biologicals for each resident are stored in the containers in which they were originally received. Facility should ensure no transfers between containers are performed by non-pharmacy personnel." 1. Upon entrance to the facility on at 8:40 AM, an observation was made of an unlocked and unsecured treatment cart (later identified as the Pineapple treatment cart) located next to the East Reception Desk. On from 10:15 AM to 10:30 AM, an observation was made of the Pineapple treatment cart located next to the East Reception Desk,, and it was unlocked and unattended. A side-by-side observation on at 10:30 AM with Staff A, Licensed Practical Nurse (LPN), was conducted who acknowledged the Pineapple	N 096	Correction are not and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulation the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Immediate Corrective Action: Carts were locked immediately. Re-education was provided to the licensed nurse assigned to east wing to ensure treatment and medication carts are kept locked and secure. Identification of other residents potentially affected: Current residents have the potential to be affected; no other resident was affected. Measures: On , re-education initiated to licensed nurses by the Director of Nursing on proper storage of drugs and biologicals. Keeping treatment and medication carts locked and secured. In-service/training will be completed for newly hired licensed nurses. Monitoring: The Director of Nursing/nursing team will complete daily audits for 4 weeks and then weekly x two months to ensure proper storage of drugs and biologicals and keeping treatment and medication carts locked and secured. The Director of Nursing will report the findings to the Quality Assurance Performance	

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N 096	Continued From page 4 treatment cart next to the East Reception Desk was left unlocked an unattended. Inside the treatment cart were several (no less than 15) prescription medications (including , creams and powders) for various residents. The nurse immediately locked the cart. An interview was conducted on at 10:30 AM with Staff A who stated she has worked at the facility since . When asked if med carts and treatment carts are left unlocked when unattended, she said, 'no, everything is supposed to be locked at all times'. 2. During an observation conducted on at 12:07 PM while doing an environmental tour of the facility with the Administrator and the Maintenance Tech, there was an unsecured and unattended med cart on the Oasis hallway. The Administrator immediately called for the nurse. An interview was conducted on at 12:10 PM with Staff A, LPN, who stated she had accidentally left the med cart unlocked when she answered a call light and entered a resident's room. 3. A medication administration (Med Pass) observation was conducted on at 6:05 PM with Staff D, Registered Nurse (RN), for Resident #23. Observation revealed Staff D poured the following medications: 400 mg one tablet for Supplement 40 mg one tablet for Polyethylene 3350 Powder to give 17 Grams for management PreserVision AREDS 2 (Multiple w/) 1 capsule for Supplement.	N 096	Improvement Committee Monthly X 3 months or until the committee determines substantial compliance.	

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N 096	Continued From page 5 During the observation, Staff D realized she had dispensed the medications and had not sanitized her throughout the Med Pass, however, she had no sanitizer bottle on top of her cart. She then walked away from the medication cart across the hallway (about 8 away with her to the cart) to the wall sanitizer dispenser leaving the dispensed medications on top of the medication cart unattended. Staff D then returned to the cart and poured water into the cup with the Polyethylene powder, stirred it with a spoon, then threw the spoon in the garbage while touching the garbage lid. She again realized she needed to use the sanitizer and again walked across the hallway to the wall sanitizer dispenser, leaving the dispensed medications unattended on top of the cart. After the medication administration observation for Resident #23, Staff D was interviewed about leaving the medications unattended on top of the cart. She stated that she just went to use the sanitizer dispenser, and it did not take too long. She was asked about the medications that she had crushed (prior to starting the Med Pass for Resident #23) and are now stored in the top drawer of the medication cart. She stated that she would discard them because the resident was not in his room. Staff D opened the top drawer, removed the small cup with the crushed medications and discarded them in the garbage container attached to the medication cart. She was asked if that was per facility's policy to discard the medications in the garbage and she stated, "I should have thrown them down the toilet". The surveyor asked Staff D to open the bottom drawer of the cart and pointed to a bottle, she picked up the bottle which was labeled "Drug	N 096		

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N 096	Continued From page 6 Disposal". Staff D acknowledged the medications are to be disposed of in the Drug Disposal bottle. Class III	N 096		
N 201 SS=D	400.022(1)(i), FS Right to Adequate and Appropriate Health Care (I) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide appropriate treatment and services to prevent complications of feeding for 1 of 1 sampled resident reviewed for ␣, Resident #43; and facility failed to ensure all nursing staff met professional standard of quality and competency skills for 1 of 24 nurses employed by the facility observed during 1 of 4 medication administration observations, to ensure the correct process was followed. The findings included: 1. Review of the facility's policy, titled, " ␣ and Medication Administration", with a revised date of , included in part the following: "Check for placement of the ␣ , Dobhoff, ␣ or before every feeding or administration of medication to	N 201	The statement made on this Plan of Correction are not and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulation the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Immediate Corrective Action: On , resident #43 was assessed by the Director of Nursing, for signs of feeding intolerance, placement and residual. Resident #43 was tolerating feeding ok, placement was confirmed with no residual. On , Re-education on	

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N 201	Continued From page 7 be sure it hasn't slipped out of the resident's . Note: Never give ˬ until proper positioning of the tube is determined. For a ˬ , Dobhoff, ˬ or check the tube for patency and position: Aspirate and measure residual ˬ contents. Return aspirant to . Inject milliliters of air through the tube while you auscultate with a stethoscope. Listen for a swooshing sound to confirm proper tube positioning." Record review for Resident #43 revealed the resident was admitted to the facility on with diagnoses that included in part the following: , , and ˬ Status. The Minimum Data Set (MDS) assessment dated documented in Section C a Brief Interview of Mental Status ( ) score of 0 indicating severe ˬ . . Review of the physician's orders for Resident #43 revealed in part the following: An order dated for Feed Order every shift. Check tube placement before initiation of formula, medication administration, and ˬ or at least every 8 hours. An order dated for Feed Order one time a day related to ˬ Status flush before and after connecting / disconnecting feeding at 2:00 PM and 10:00 AM via ˬ 150n cc of water two times a day. An order dated for Feed Order every night shift. Complete tube site care every day. An order dated for Feed Order every hour for nutrition and prevent clogged tubing flush hourly with 30 cc for 20 hours while feed running 2pm to 10 am. An order dated for Feed Order	N 201	feeding administration was immediately provided to staff A, the licensed Practical Nurse. Identification of other residents potentially affected: Current residents have the potential to be affected; however, based on the residents assessment and observation completed, no resident was affected. Measures: On , staff A was provided with competency skills training on Feeding Administration by the Director of Nursing. a. Verifying the five rights of administration b. Safety & Proper Positioning c. Tube Placement d. Residual e. Flush f. Control On , Relias training was completed by staff A, on feeding. Inservice/training will be completed for newly hired licensed nurses. Monitoring: The Director of Nursing/nursing team will complete daily audits for 4 weeks and then and then weekly x 2 months to ensure licensed nurses follow the policy and procedure for ˬ and provide appropriate treatment and services to prevent complications of feeding. The Director of Nursing will report the findings to the Quality Assurance Performance Improvement Committee Monthly X 3 months or until the committee determines substantial compliance.	

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N 201	Continued From page 8 every shift Continuous Feed: Check residual every hours, prior to irrigation and PRN (Confirm with physician regarding withholding feedings). An order dated for Feed Order every shift Observe for signs of , , , , , distention, , , , , and breath sounds every shift. An order dated for Feed Order every shift Elevate of bed 30 to 45 degrees at all times during feeding and for at least 30 minutes after stopped. An order dated for Feed Order every shift for nutrition Jevity 1.5 via at 70cc/hour x 20 hours off at 10:00 AM and on at 2:00 PM. An order dated for Enhanced Barrier Precautions. Review of the care plans for Resident #43 dated with a focus on the resident required to provide nutrition and hydration due to , , , revealed: 'The resident is at risk for loss and due to tube status and was recently hospitalized s/p [status post] and . Other conditions that could impact the resident's nutritional status include diagnoses of 's , , , and . The goals were for the resident to have no significant change in the next 30 and 180 days, will have no s/s , will have no s/s of , or choking and will have no N/V/C/D [/ / / / } related to , by the next review date. The interventions included in part the following: Provide resident with feeding as ordered by my Medical Doctor (MD). Provide flushes as ordered by my MD. Family has preference for Jevity products.'	N 201		

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N 201	Continued From page 9 On at 2:18 PM, an observation was made of Staff A, Licensed Practical Nurse (LPN), who entered the room of Resident #43 to connect to the resident. Staff A connected the to the resident's and turned on the without checking placement of the or checking the for patency. An interview was conducted on at 2:25 PM with Staff A who was asked about checking for placement, patency and residual of the prior to connecting the . Staff A stated she checked all of that between 12:00 PM and 1:00 PM when she administered medications to the resident. 2. Review of the facility's policy titled, "Orientation for Professional Staff," dated , included the following: "To strive to assure that all nurses possess the competencies and skill sets necessary to provide nursing and related services to meet the residents" needs safely and in a manner that promotes each resident's rights, physical, mental, and wellbeing. Procedure: 1. The Orientation Checklist for Professional Staff is completed by the Director of Nursing (DON), who will provide orientation to the new employee." Review of the facility's policy, titled, "Medication Administration & Management," dated , included the following: "To strive to ensure safe and efficient administration of medications to residents in [facility name]." Procedure: 3. Dose Preparation: All authorized community staff should adhere the following guidelines: f. Verify that the medication name and dose are correct.	N 201		

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N 201	Continued From page 10 4. Prior to Medication Administration: All authorized community staff should adhere to the following guidelines: a. Verify the correct drug, correct dose, correct rate, correct time and current resident prior to each medication administration. b. Confirm that the Medication Administration Record (MAR) reflects the most recent medication order." On at 5:54 PM in the 200s unit hallway, the surveyor approached Staff D, Registered Nurse (RN), who was at a medication cart and actively crushing medications. She was asked if she had any other medication administration to do, she stated "yes". Staff D poured the crushed medications into the medication cup and realized she did not have apple sauce on the medication cart. She stated she would get the apple sauce and then she stored the cup of crushed medications in the top drawer of the medication cart and locked the cart. She went down the hallway, around the corner where the nurses' station was located. An observation of the medication cart revealed only a pill crusher machine and a pitcher of water on top of the cart (no computer, notepad or cooler was observed). Staff D returned at 5:56 PM with a cooler (containing apple sauce and Boost supplement drinks) and a laptop computer. She sat them on top of the medication cart and attempted to log into the laptop but was not able to. She stated that she would be right because she must log out of the other computer and at 5:57 PM left again, went down the hallway and around the corner where the nurses' station was located. She returned at 6:04 PM and was able to log into the laptop computer and began dispensing medications for a resident for the medication administration observation.	N 201		

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N 201	Continued From page 11 An interview was conducted with Staff D following the medication administration observation who stated she has worked at the facility for a month. The surveyor inquired about the medications that she previously had crushed and stored in the top drawer of the medication cart. She stated that she would discard them because the resident is not in his room. Staff D was asked how she knew which medications to dispense if she did not have the laptop computer on the medication cart. She then stated that she is always scheduled to this hallway, she knows her residents well and she had pulled up the resident's MAR in the other computer (which was located by the nurses' station). Staff D was asked if this is per facility's standards, she stated that this laptop computer gives her problems, and she does not like using it. She also stated management is aware, but the laptop still does not work well. During the medication administration, the surveyor observed the laptop was able to display the MAR for the resident. On at 6:50 PM, the surveyor discussed the medication administration observation conducted with Staff D with the Director of Nursing (DON). She was upset and stated that they have recently reviewed medication administration and Staff D is a new nurse. She stated there will be lots of education and training scheduled. On at 1:25 PM, an interview was conducted with the Administrator. She stated Staff D recently became an RN. The NHA stated she was a Licensed Practical Nurse (LPN) prior. The Administrator stated the staff developer, who was also the Assisting Director of Nursing (ADON), was responsible for Staff D to complete	N 201		

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N 201	Continued From page 12 the Orientation Checklist for Professional Staff. She acknowledged the ADON was terminated last Friday due to inconsistency in her work. The Administrator was beside herself when she was told about the medication administration observation that was conducted with Staff D. She stated that it appeared that Staff D was not prepared to work, and it is not acceptable. A side-by-side review of Staff D's Orientation Checklist for Professional Staff was conducted with the Administrator. Review of the medication administration section of the checklist dated revealed Staff D required education on preparing and organizing everything needed before starting Medication Administration. Class III	N 201		

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

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F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted on through at Willowbrooke Court at St. Andrews Estates. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 693 SS=D	Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Nutrition (Includes naso- and tubes, both and endoscopic , and fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by methods unless the resident's clinical condition demonstrates that feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of feeding including but not limited to , , , , , abnormalities, and -. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide appropriate treatment and services to prevent complications of feeding for 1 of 1 sampled resident reviewed for , Resident #43.	F 693	The statement made on this Plan of Correction are not and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2025

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.

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F 693	Continued From page 1 The findings included: Review of the facility's policy, titled, "[redacted] and Medication Administration", with a revised date of [redacted], included in part the following: "Check for placement of the [redacted], Dobhoff, [redacted] or [redacted] before every feeding or administration of medication to be sure it hasn't slipped out of the resident's [redacted]. Note: Never give [redacted] until proper positioning of the tube is determined. For a [redacted], Dobhoff, [redacted] or [redacted] check the tube for patency and position: Aspirate and measure residual [redacted] contents. Return aspirant to [redacted]. Inject [redacted] milliliters of air through the tube while you auscultate with a stethoscope. Listen for a swooshing sound to confirm proper tube positioning." Record review for Resident #43 revealed the resident was admitted to the facility on [redacted] with diagnoses that included in part the following: [redacted], [redacted], and [redacted], Status. The Minimum Data Set (MDS) assessment dated [redacted] documented in Section C a Brief Interview of Mental Status ([redacted]) score of 0 indicating severe [redacted]. Review of the physician's orders for Resident #43 revealed in part the following: An order dated [redacted] for [redacted] Feed Order every shift. Check tube placement before initiation of formula, medication administration, and [redacted] or at least every 8 hours. An order dated [redacted] for [redacted] Feed Order one time a day related to [redacted], Status flush before and after connecting / disconnecting	F 693	and state regulation the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Immediate Corrective Action: On [redacted], resident #43 was assessed by the Director of Nursing, for signs of feeding intolerance, placement and residual. Resident #43 was tolerating feeding ok, placement was confirmed with no residual. On [redacted], Re-education on feeding administration was immediately provided to staff A, the licensed Practical Nurse. Identification of other residents potentially affected: Current residents have the potential to be affected; however, based on the residents assessment and observation completed, no resident was affected. Measures: On [redacted], staff A was provided with competency skills training on [redacted] Feeding Administration by the Director of Nursing. a. Verifying the five rights of administration b. Safety & Proper Positioning c. Tube Placement d. [redacted] Residual e. Flush f. [redacted] Control On [redacted], Relias training was	

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F 693	Continued From page 2 feeding at 2:00 PM and 10:00 AM via , 150n cc of water two times a day. An order dated for Feed Order every night shift. Complete tube site care every day. An order dated for Feed Order every hour for nutrition and prevent clogged tubing flush hourly with 30 cc for 20 hours while feed running 2pm to 10 am. An order dated for Feed Order every shift Continuous Feed: Check residual every hours, prior to irrigation and PRN (Confirm with physician regarding withholding feedings). An order dated for Feed Order every shift Observe for signs of , , , distention, , , , and breath sounds every shift. An order dated for Feed Order every shift Elevate of bed 30 to 45 degrees at all times during feeding and for at least 30 minutes after stopped. An order dated for Feed Order every shift for nutrition Jevity 1.5 via , at 70cc/hour x 20 hours off at 10:00 AM and on at 2:00 PM. An order dated for Enhanced Barrier Precautions. Review of the care plans for Resident #43 dated with a focus on the resident required to provide nutrition and hydration due to , , , revealed: 'The resident is at risk for loss and due to tube status and was recently hospitalized s/p [status post] and . Other conditions that could impact the resident's nutritional status include diagnoses of 's , , , and	F 693	completed by staff A, on feeding. Inservice/training will be completed for newly hired licensed nurses. Monitoring: The Director of Nursing/nursing team will complete daily audits for 4 weeks and then and then weekly x 2 months to ensure licensed nurses follow the policy and procedure for and provide appropriate treatment and services to prevent complications of feeding. The Director of Nursing will report the findings to the Quality Assurance Performance Improvement Committee Monthly X 3 months or until the committee determines substantial compliance.	

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F 693	Continued From page 3 , . The goals were for the resident to have no significant change in the next 30 and 180 days, will have no s/s , will have no s/s of , or choking and will have no N/V/C/D [/ / /] related to by the next review date. The interventions included in part the following: Provide resident with feeding as ordered by my Medical Doctor (MD). Provide flushes as ordered by my MD. Family has preference for Jevity products.' On at 2:18 PM, an observation was made of Staff A, Licensed Practical Nurse (LPN), who entered the room of Resident #43 to connect to the resident. Staff A connected the to the resident's and turned on the without checking placement of the or checking the for patency. An interview was conducted on at 2:25 PM with Staff A who was asked about checking for placement, patency and residual of the prior to connecting the . Staff A stated she checked all of that between 12:00 PM and 1:00 PM when she administered medications to the resident.	F 693		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and well-being of each resident, as determined by	F 726		

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F 726	Continued From page 4 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure all nursing staff professional standard of quality for 1 of 24 nurses employed by the facility observed during 1 of 4 medication administration observations, to ensure the correct process was followed. The findings included: Review of the facility's policy titled, "Orientation for Professional Staff," dated , included the following: "To strive to assure that all nurses possess the competencies and skill sets necessary to provide nursing and related services	F 726	The statement made on this Plan of Correction are not and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulation the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Immediate Corrective Action: Staff D, the	

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F 726	Continued From page 5 to meet the residents" needs safely and in a manner that promotes each resident's rights, physical, mental, and , , wellbeing. Procedure: 1. The Orientation Checklist for Professional Staff is completed by the Director of Nursing (DON), who will provide orientation to the new employee." Review of the facility's policy, titled, "Medication Administration & Management," dated , included the following: "To strive to ensure safe and efficient administration of medications to residents in [facility name]. Procedure: 3. Dose Preparation: All authorized community staff should adhere the following guidelines: f. Verify that the medication name and dose are correct. 4. Prior to Medication Administration: All authorized community staff should adhere to the following guidelines: a. Verify the correct drug, correct dose, correct rate, correct time and current resident prior to each medication administration. b. Confirm that the Medication Administration Record (MAR) reflects the most recent medication order." On at 5:54 PM in the 200s unit hallway, the surveyor approached Staff D, Registered Nurse (RN), who was at a medication cart and actively crushing medications. She was asked if she had any other medication administration to do, she stated "yes". Staff D poured the crushed medications into the medication cup and realized she did not have apple sauce on the medication cart. She stated she would get the apple sauce and then she stored the cup of crushed medications in the top drawer of the medication	F 726	Registered Nurse, was immediately pulled from the assignment. On staff D was re-educated by the Director of Nursing on medication administration and management to ensure safe and efficient administration of medications to residents. Dispensing, dose preparation and follow the correct medication administration guidelines. Specific competencies and skill set necessary to provide nursing and related services to meet the residents needs safely. Identification of other residents potentially affected: Current residents have the potential to be affected; however, based on the resident assessment and observation completed, no resident was affected. Measures: On , staff D was provided with competency skills training by the Director of Nursing to ensure staff D possess the competencies and skill sets necessary to provide nursing and related services to meet the residents needs safely. a. Verifying the five rights of administration right person, medication, route, time and dose. b. Prepare Place medication in cup, if medication needs to be or can be crushed. c. control - Perform hygiene. Use control measures and standard precautions. d. Administration. e. Documentation.	

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F 726	Continued From page 6 cart and locked the cart. She went down the hallway, around the corner where the nurses' station was located. An observation of the medication cart revealed only a pill crusher machine and a pitcher of water on top of the cart (no computer, notepad or cooler was observed). Staff D returned at 5:56 PM with a cooler (containing apple sauce and Boost supplement drinks) and a laptop computer. She sat them on top of the medication cart and attempted to log into the laptop but was not able to. She stated that she would be right because she must log out of the other computer and at 5:57 PM left again, went down the hallway and around the corner where the nurses' station was located. She returned at 6:04 PM and was able to log into the laptop computer and began dispensing medications for a resident for the medication administration observation. An interview was conducted with Staff D following the medication administration observation who stated she has worked at the facility for a month. The surveyor inquired about the medications that she previously had crushed and stored in the top drawer of the medication cart. She stated that she would discard them because the resident is not in his room. Staff D was asked how she knew which medications to dispense if she did not have the laptop computer on the medication cart. She then stated that she is always scheduled to this hallway, she knows her residents well and she had pulled up the resident's MAR in the other computer (which was located by the nurses' station). Staff D was asked if this is per facility's standards, she stated that this laptop computer gives her problems, and she does not like using it. She also stated management is aware, but the laptop still does not work well. During the	F 726	On , licensed nurses were re-educated by the Director of Nursing on medication administration and management to ensure safe and efficient administration of medications to residents. Dispensing, dose preparation and follow the correct medication administration guidelines. Specific competencies and skill set necessary to provide nursing and related services to meet the residents needs safely. Training and orientation competency skills will be completed for newly hired licensed nurses. On , Relias training on medication administration and management was completed by staff D, registered nurse. On and , staff D completed 1:1 training with senior registered nurse to ensure medication administration processes are followed. Monitoring: The Director of Nursing/nursing team will complete daily audits for 4 weeks and then weekly audits x 3 months to ensure licensed nurses are following the medication administration process and possess competency skill sets to provide nursing and related services to meet residents needs safely. The Director of Nursing will report the findings to the Quality Assurance Performance Improvement Committee Monthly x 4 months or until the committee determines substantial compliance.	

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F 726	Continued From page 7 medication administration, the surveyor observed the laptop was able to display the MAR for the resident. On at 6:50 PM, the surveyor discussed the medication administration observation conducted with Staff D with the Director of Nursing (DON). She was upset and stated that they have recently reviewed medication administration and Staff D is a new nurse. She stated there will be lots of education and training scheduled. On at 1:25 PM, an interview was conducted with the Administrator. She stated Staff D recently became an RN. The NHA stated she was a Licensed Practical Nurse (LPN) prior. The Administrator stated the staff developer, who was also the Assisting Director of Nursing (ADON), was responsible for Staff D to complete the Orientation Checklist for Professional Staff. She acknowledged the ADON was terminated last Friday due to inconsistency in her work. The Administrator was beside herself when she was told about the medication administration observation that was conducted with Staff D. She stated that it appeared that Staff D was not prepared to work, and it is not acceptable. A side-by-side review of Staff D's Orientation Checklist for Professional Staff was conducted with the Administrator. Review of the medication administration section of the checklist dated revealed Staff D required education on preparing and organizing everything needed before starting Medication Administration.	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		

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F 755	Continued From page 8 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, the facility failed to maintain a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, to determine that drug records are in order and that an account of all	F 755	The statement made on this Plan of Correction are not and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulation the center has taken	

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F 755	Continued From page 9 controlled drugs is maintained and periodically reconciled for 1 of 5 sampled residents reviewed for controlled medications, Resident #4. The findings included: Review of the facility's policy titled, "Medication, Controlled Substances", with a revised date of , included in part the following: "To strive to ensure that strict management of controlled substances is maintained as evidence by special handling, storage , disposal and record keeping. When a resident receives a , the licensed nurse signs off each dose of the controlled medication given by documenting the following on the sheet and the electronic medication administration record [eMAR]." Record review for Resident #4 revealed a most recent readmission to the facility on with diagnoses that included in part the following: Displaced Supracondylar Without Intracondylar Extension of Lower End of Right Subsequent Encounter for Closed with Routine Healing, on Same Level From Slipping Tripping and Stumbling Without Subsequent Striking Against Object Subsequent Encounter, in Left , and Around Internal , Left Subsequent Encounter. The Minimum Data Set dated documented in Section C a Brief Interview of Mental Status score of 14 indicating a response. Review of the physician's orders for Resident #4 revealed an order dated for Oral Tablet 50 MG ( ) Give 1 tablet by every 6 hours as needed for , was discontinued .	F 755	or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Immediate Corrective Action: On , resident #4 , screening completed, residents , level was noted to be at zero. On , licensed nurses were re-educated by the Director of Nursing on the importance of ensuring medication administrations are signed off in pharmacy log and on Medication Administration Record (MAR) in Point Click Care for accurate account of controlled medications. Identification of other residents potentially affected: Quality review audit of completed. Current residents have the potential to be affected; resident #4 was not affected. Measures: On , licensed nurses were re-educated by the Director of Nursing on the importance of ensuring all medications administration are signed off in pharmacy log and on Medication Administration Record (MAR) in Point Click Care for accurate account of controlled medications. In-services/training will be completed for newly hired licensed nurses. Monitoring: The Director of Nursing/nursing team will complete daily audits during clinical meeting for 4 weeks	

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F 755	Continued From page 10 Review of the physician's orders for Resident #4 revealed an order dated for Oral Tablet 50 MG ( ) Give 1 tablet by every 8 hours as needed for moderate (,). Review of Controlled Medication Utilization Record for Resident #4 for 50mg tablet give 1 tablet by every 8 hours as needed for , documented in part the following: On at 1:30 AM, 1 tablet was removed. On at 7:00 AM, 1 tablet was removed. Review of the Medication Administration Record for Resident #4 for the month of , revealed no documentation of having been administered on at 1:30 AM or on at 7:00 AM. An interview was conducted on at 11:00 AM with Staff C, Registered Nurse (RN), who stated she has worked at the facility for 5 years. When asked about the process of removing and administering controlled medications, she stated they remove the medication, mark it on the Control Sheet, and sign it off on the MAR once it is given to the resident. An interview was conducted on at 11:15 AM with Staff A, Licensed Practical Nurse (LPN), who stated she has worked at the facility for 3 years. When asked about the process for removing and administering controlled medications, she stated they remove the medication, mark it on the Control Sheet, and sign it off on the MAR once it is given to the resident.	F 755	and then weekly x 3 months to ensure records are in order and that an account of all controlled drugs is maintained and reconciled. Director of Nursing will report the findings to the Quality Assurance Performance Improvement Committee Monthly X 4 months or until the committee determines substantial compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 11	F 757		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug ,); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to monitor behaviors as per physician's orders for 2 of 5 sampled residents reviewed for unnecessary medications, Resident #7 and Resident #23. The findings included: Review of the facility's policy, titled, " , Medications," dated , included the following: "3. The community supports the goal of determining the underlying cause of behavioral	F 757	The statement made on this Plan of Correction are not and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulation the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 757	Continued From page 12 symptoms so that appropriate treatment of the environment, medical, and/or behavioral interventions, as well as , , , medications, (if clinically necessary), can be used to meet the needs of the individual resident. Procedure: 1. The physician or nurse practitioner, as allowed per state requirements, will document and substantiate reasons for use of the medication in the progress notes. The notes are to include: c. Identification of targeted symptoms/behaviors. 8. Documentation, in the care plan and nursing notes, should reflect the monitoring of the resident for the desired responses of medication use, in addition to the non-pharmacological interventions attempted. 9. Presence or absence of adverse behavior and side effects from medication use, if present, will be documented on the pharmacy provided behavior monitoring form, administration record, or in the progress notes." 1. Record review revealed Resident #7 was admitted to the facility on with diagnoses to include 's , , and Major , . Section C of the Minimum Data Set (MDS) assessment dated revealed Resident #7 had a ( ) score of 00, indicating severe , . The physician order summary report showed an order for (a , , , medication) at 50 milligrams, to give 1 tablet by in the morning for , dated . Continued review of the order summary report revealed an order for behaviors: "monitor the	F 757	Immediate Corrective Action: On , residents #7 and #23 clinical charts were reviewed. Licensed nurses were re-educated on following physician□s orders for monitoring of behavior and documentation of intervention codes. Identification of other residents potentially affected: Quality review audit of current residents at risk for behavioral monitoring and interventions was completed. No other residents were affected. Measures: On , re-education initiated to licensed nurses by the Director of Nursing on following physician□s orders for monitoring of behavior and documentation of intervention codes. In-service/training will be completed for newly hired licensed nurses. Monitoring: The Director of Nursing/nursing team will complete daily audits during clinical meeting for 4 weeks and then weekly x 3 months to ensure physician□s orders are being followed for behavior monitoring and documentation to ensure the appropriate treatment and or behavioral interventions are being used to meet the needs of the residents. Director of Nursing will report the findings to the Quality Assurance Performance Improvement Committee Monthly X 4 months or until the committee determines substantial compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105355	A. BUILDING _____ B. WING _____	05/01/2025

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WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 757	Continued From page 13	F 757		

following: feeling , tearful, emptiness or hopelessness, angry outbursts, irritability or frustration, loss of interest or pleasure in most or normal activities such as hobbies, sports or reading, sleep disturbances, including or sleeping too much. Indicate with (Y) if signs/symptoms noted, then write progress note. Indicate with (N) if no signs/symptoms note every shift with a start date . In addition, if a behavior was observed, there was a physician's order to enter the following intervention codes: (1)=Redirect (2)=One on one (3)=Ambulate (4)=Activity (5)=Return to room (6)= Toileted (7)=Give food (8)=Give fluids (9)=Change position (10)=Encourage to rest (11)=Backrub (12)=Refer to nurse's notes (13)=Assess for , . outcome codes: (+)=Improved (-)=Worsened (0)=Unchanged (N)=See progress notes, every shift start date ."

Record review of the , Medication Administration Record (MAR) revealed Resident #7 was monitored for behavior and interventions. However, on during the day and night shift and on night shift, it had documented behaviors were observed (marked in the MAR with a "Y"), but there were no intervention codes documented on those days or in nursing progress notes.

Review of the nursing progress notes dated documented: was a behavior observed? Yes, however, no other documentation for which of the behaviors was observed, or the intervention that was implemented. On , the nursing progress note documented a behavior observed (not documented in the MAR), however no additional documentation was found regarding which behavior was observed and what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 757	Continued From page 14	F 757		

interventions were implemented. Further review of the progress notes, on documented behavior was observed (not documented in the MAR), and no follow up documentation for interventions.

2. Record review revealed Resident #23 was admitted to the facility on with diagnoses of , , and . Section C of the MDS dated revealed Resident #23 had a of 00, indicating severe , . The physiciian order summary report showed an order for , (a , , medication) at 7.5 milligrams, to give 1 tablet by at bedtime for , dated .

Continued review of the order summary report revealed an order for behaviors: "monitor the following: feeling , tearful, emptiness or hopelessness, angry outbursts, irritability or frustration, loss of interest or pleasure in most or normal activities such as hobbies, sports or reading, sleep disturbances, including or sleeping too much. Indicate with (Y) if signs/symptoms noted, then write progress note. Indicate with (N) if no signs/symptoms note every shift with a start date . Further review revealed if a behavior was observed to enter the following intervention codes: (1)=Redirect (2)=One on one (3)=Ambulate (4)=Activity (5)=Return to room (6)= Toileted (7)=Give food (8)=Give fluids (9)=Change position (10)=Encourage to rest (11)=Backrub (12)=Refer to nurse's notes (13)=Assess for , outcome codes: (+)=Improved (-)=Worsened (0)=Unchanged (N)=See progress notes, every shift start date ."

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 757	Continued From page 15	F 757		

The care plan that was initiated on showed Resident #23 demonstrated behavior(s) such as restlessness, agitation, trying to get up the wheelchair without assistance and not easily to be redirected. Some of the interventions were shown to monitor the behavior episodes and attempt to determine underlying causes; consider location, time of day, people involved, and situations; and document my behavior and potential causes.

Record review of the , MAR revealed Resident #23 was monitored for behavior however, the documentation was "check" marks instead of Yes or No to indicate if signs/symptoms were noted as per the physician's orders. Further review revealed intervention codes were documented on , , , and during the day shift. Review of the nursing progress notes for those dates revealed no documentation on the resident's behavior or the interventions that were put in place.

An interview was conducted on at 10:59 AM with Staff A, Licensed Practical Nurse (LPN), who stated she has worked at the facility since . She stated residents on , , , medication are monitored for behaviors daily. She also stated that any change in behavior is documented in the progress notes and will include what happened, the interventions that were implemented, then the provider is contacted, and monitoring of the resident will continue.

An interview was conducted on at 11:11 AM with Staff C, Registered Nurse (RN), who stated she has worked at the facility for 4 years. She stated they used to document the behaviors

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 16 on paper, however, now they document in the computer which include the behavior, interventions and the side effects of the , , , medications. Staff C stated the physician's orders provides instructions on what to document and use codes for the interventions and then add it to the progress notes. An interview was conducted on at 3:00 PM with the Director Of Nursing (DON) who stated that the behaviors are monitored and documented in the progress notes. During the interview, a side-by-side review of Resident #7 and Resident #23's , MAR was conducted, the DON acknowledged that the documentation did not follow the physician's orders for monitoring of behaviors for both residents.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 17 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Prevention and Control Act of 1976 and other drugs subject to , except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, the facility failed to secure 1 of 3 medication carts, failed to secure 1 of 2 treatment carts, and failed to secure and properly dispose of medications (meds) during 1 of 4 medication administration observations. The findings included: Review of the facility's policy, titled, "Storage and Expiration Dating of Medications and Biologicals", with a revised date of , included in part, the following: "Facility should ensure medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators / freezers of sufficient size to prevent crowding. Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. Facility should ensure the medications and biologicals for each resident are stored in the containers in which they were originally received. Facility should ensure no transfers between containers are performed by non-pharmacy personnel." 1. Upon entrance to the facility on at 8:40 AM, an observation was made of an	F 761	The statement made on this Plan of Correction are not and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulation the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Immediate Corrective Action: Carts were locked immediately. Re-education was provided to the licensed nurse assigned to east wing to ensure treatment and medication carts are kept locked and secure. Identification of other residents potentially affected: Current residents have the potential to be affected; no other resident was affected. Measures: On , re-education initiated to licensed nurses by the Director of Nursing on proper storage of drugs and biologicals. Keeping treatment and	

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 18 unlocked and unsecured treatment cart (later identified as the Pineapple treatment cart) located next to the East Reception Desk. On from 10:15 AM to 10:30 AM, an observation was made of the Pineapple treatment cart located next to the East Reception Desk, and it was unlocked and unattended. A side-by-side observation on at 10:30 AM with Staff A, Licensed Practical Nurse (LPN), was conducted who acknowledged the Pineapple treatment cart next to the East Reception Desk was left unlocked an unattended. Inside the treatment cart were several (no less than 15) prescription medications (including , creams and powders) for various residents. The nurse immediately locked the cart. An interview was conducted on at 10:30 AM with Staff A who stated she has worked at the facility since . When asked if med carts and treatment carts are left unlocked when unattended, she said, 'no, everything is supposed to be locked at all times'. 2. During an observation conducted on at 12:07 PM while doing an environmental tour of the facility with the Administrator and the Maintenance Tech, there was an unsecured and unattended med cart on the Oasis hallway. The Administrator immediately called for the nurse. An interview was conducted on at 12:10 PM with Staff A, LPN, who stated she had accidentally left the med cart unlocked when she answered a call light and entered a resident's room.	F 761	medication carts locked and secured. In-service/training will be completed for newly hired licensed nurses. Monitoring: The Director of Nursing/nursing team will complete daily audits for 4 weeks and then weekly x two months to ensure proper storage of drugs and biologicals and keeping treatment and medication carts locked and secured. The Director of Nursing will report the findings to the Quality Assurance Performance Improvement Committee Monthly X 3 months or until the committee determines substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 19	F 761		

3. A medication administration (Med Pass) observation was conducted on at 6:05 PM with Staff D, Registered Nurse (RN), for Resident #23. Observation revealed Staff D poured the following medications:
400 mg one tablet for Supplement
40 mg one tablet for
Polyethylene 3350 Powder to give 17 Grams for management
PreserVision AREDS 2 (Multiple w/) 1 capsule for Supplement.

During the observation, Staff D realized she had dispensed the medications and had not sanitized her throughout the Med Pass, however, she had no sanitizer bottle on top of her cart. She then walked away from the medication cart across the hallway (about 8 away with her to the cart) to the wall sanitizer dispenser leaving the dispensed medications on top of the medication cart unattended. Staff D then returned to the cart and poured water into the cup with the Polyethylene powder, stirred it with a spoon, then threw the spoon in the garbage while touching the garbage lid. She again realized she needed to use the sanitizer and again walked across the hallway to the wall sanitizer dispenser, leaving the dispensed medications unattended on top of the cart.

After the medication administration observation for Resident #23, Staff D was interviewed about leaving the medications unattended on top of the cart. She stated that she just went to use the sanitizer dispenser, and it did not take too long. She was asked about the medications that

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 20 she had crushed (prior to starting the Med Pass for Resident #23) and are now stored in the top drawer of the medication cart. She stated that she would discard them because the resident was not in his room. Staff D opened the top drawer, removed the small cup with the crushed medications and discarded them in the garbage container attached to the medication cart. She was asked if that was per facility's policy to discard the medications in the garbage and she stated, "I should have thrown them down the toilet". The surveyor asked Staff D to open the bottom drawer of the cart and pointed to a bottle, she picked up the bottle which was labeled "Drug Disposal". Staff D acknowledged the medications are to be disposed of in the Drug Disposal bottle.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and policy review, the facility failed to follow standards of professional practice for food safety, as evidenced by raw chicken and Mighty Shakes were stored in the refrigerator past the recommended time frames for food safety. This had the potential to affect 42 of 44 residents on oral diets. The findings included: Review of the facility's policy included a Food Storage Chart by HACCP, last revised in . It said that raw meat can be stored in the refrigerator for 4 days (including the day of delivery). Review of the United States Food and Drug Administration's (USFDA) Refrigerator and Freezer Storage chart dated , stated that uncooked chicken can be stored in the refrigerator for days. According to the USFDA, "these short but safe time limits will help keep refrigerated food, 40' F, from spoiling or becoming dangerous." The chart also stated that product dates were not a guide for the safe use of a product. Photographic Evidence Obtained. Review of the product guide for Mighty shakes revealed that after Mighty shakes were thawed, the shelf life was 14 days when refrigerated. Photographic Evidence Obtained. During the initial observation of the kitchen on , at 9:00 AM, the surveyor was accompanied by the Director of Culinary Services (DCS) & Staff B. The following observations and	F 812	The statement made on this Plan of Correction are not and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulation the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Immediate Corrective Action: The box of chicken and mighty shake was discarded. Identification of other residents potentially affected: Current residents have the potential to be affected; however, based on inspection and not using the chicken or mighty shake no residents were affected. Measures: On , re-education provided by the Director of Culinary Services to the culinary team members on following the standards of professional practice for food safety. Following the culinary services policy and procedures food storage chart for dry food and refrigerated storage. New team members will be educated to follow the standards of professional practice for food safety upon hire. Monitoring: The Director of Culinary Services/Executive Chef will complete daily audits for 4 weeks and then weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 812	Continued From page 22 interviews were occurred: a. A forty-, box of boneless, skinless, chicken was observed in the walk-in refrigerator (Refrigerator #1). The lid of the box had a small white rectangular sticker with the date on it. When the DCS was asked what the date on the sticker meant, she said the date , was the date that the chicken was received at this facility. When the DCS was asked when the chicken was pulled out of the freezer, she said it was not put in the freezer after it arrived. She explained that after delivery, it was placed directly into the refrigerator. When the DCS was asked how long raw chicken was safe to use when stored in the refrigerator, the DCS said it was good to use for about one week. The DCS said the chicken had Cryovac packaging, (a low form of wrapping, that extends the shelf life of food). There was a large white rectangular sticker on the lower half of the box of raw chicken that came from the vendor / food distributor. It had the "packed" date, , printed in a large font. The packed date represented the date that the chicken was packed into the plastic bag before it was boxed for shipping from the distributor. There was no "use by" date on the box of raw chicken. On the date of the initial survey, the box of raw chicken was stored in the refrigerator for 6 days. Photographic Evidence Obtained. b. In refrigerator #1, a box of Mighty shakes, dated , was observed on the shelf. The directions "Keep Frozen" were printed on the top edge of each 4-ounce carton. When asked what the date represented, the DCS said	F 812	for 2 months to ensure all items are following the professional practice for food safety. The Director of Culinary Services will report the findings to the Quality Assurance Performance Improvement Committee Monthly X 3 months or until the committee determines substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 812	Continued From page 23	F 812		

that's the date we received the item from the vendor. When asked when this item was pulled out from the freezer, Staff B said it was pulled out about 1 month ago. There was no use by date on the box of Mighty shakes. The surveyor informed the DCS and Staff B that Mighty shakes were safe to use for 14 days after they were removed from the freezer. The DCS said she was unaware of this and agreed to follow-up with the vendor of the Mighty Shakes for information related to the storage of the shakes in the refrigerator.

During an interview with the DCS on at 3:08 PM, the DCS said she received a printout from the distributor that said that the chicken had a shelf life of 16 days. The surveyor took a photo of the email printout that showed "16" in the box next to the word shelf, there was no mention of refrigeration or freezing on the printout. In addition, the DCS said she called the vendor of the Mighty Shakes. She said that the facility's sales representative confirmed that the Mighty shakes must be used within 14 days after they were removed from the freezer.

During a follow-up tour of the main kitchen on at 11:20 AM, the DCS and the surveyor entered Refrigerator #1 to revisit the boxes of uncooked chicken . The DCS commented, "we now have "use by" days written on these boxes." She showed the surveyor the "use by" label was dated to indicate the raw chicken was to be used within 16 days of the packed date. On , the raw chicken was in the facility's refrigerator for 9 days. The surveyor observed that the plastic wrap was a "loose" plastic bag around the chicken. The surveyor reminded the DCS that on the DCS said the chicken had Cryovac packaging.

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 812	Continued From page 24 The surveyor pointed to items in the refrigerator that appeared to be wrapped with a Cryovac (low ,,) method. The wrap for some meat in the refrigerator appeared to have a tight plastic covering that was sealed with a low ,, packaging method. The surveyor clarified with the DCS that the box of boneless, skinless, chicken was not packaged with a low ,, process. The DCS acknowledged this. The packaging specifications were provided to the surveyor. There was no indication that low ,, packaging was used. The surveyor informed the DCS that the USFDA's Refrigerator and Freezer storage chart for food safety recommended raw chicken in the refrigerator for days. The DCS said she just followed recommendations from the distributor based on that individual product.	F 812		
F 880 SS=D	Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Control The facility must establish and maintain an prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable and . §483.80(a) prevention and control program. The facility must establish an prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling	F 880		

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 880	Continued From page 25 and communicable for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable or before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable or should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of ; ( )When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the ; and (vi)The hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 880	Continued From page 26 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of . §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to perform hygiene during 1 of 4 medication (med) administration observations and failed to wear appropriate Personal Protective Equipment (PPE) ˬ ˬ connection for 1 of 1 sampled residents reviewed for (Resident #43). The findings included: Review of the facility's policy titled, "Guidelines for Isolation Precautions" with a revised date of included in part the following: Under section "Enhanced Barrier Precautions (EBP) 1. EBP are used as an control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs). 2. This precaution expands on the use of PPE and refers to the use of gown and gloves during high-contact resident care activities (unless otherwise indicated as part of Standard Precautions) that provide opportunities for transfer of MDROs to staff and clothing. 3. EBP will be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: a. or ˬ medical devices, regardless of MDRO colonization status.	F 880	The statement made on this Plan of Correction are not and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulation the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Immediate Corrective Action: A. Staff A and staff D were immediately re-educated on Control practices. B. Staff A and staff D were re-educated on performing hygiene during care and medication administration and following guidelines for Enhanced Barrier Precautions (EBP) by wearing appropriate Personal Protective Equipment (PPE) during high-contact resident care activities. Identification of other residents potentially affected: Quality Review audit related to control practices was completed.	

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 880	Continued From page 27 5. Implementation - High-contact resident care activities that require gown and glove use for EBP include: g. Device care or use: central line, , , ,

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 880	Continued From page 28	F 880		

every night shift. Complete tube site care every day.
An order dated for Feed Order every hour for nutrition and prevent clogged tubing flush hourly with 30 cc for 20 hours while feed running 2pm to 10 am
An order dated for Feed Order every shift Continuous Feed: Check residual every hours, prior to irrigation and PRN (Confirm with physician regarding withholding feedings).
An order dated for Feed Order every shift Observe for signs of , , , distention, , , , and breath sounds every shift.
An order dated for An order dated for Feed Order every shift Elevate of bed 30 to 45 degrees at all times during feeding and for at least 30 minutes after stopped.
An order dated for Feed Order every shift for nutrition Jevity 1.5 via at 70cc/hour x 20 hours off at 10:00 AM and on at 2:00 PM
An order dated for Enhanced Barrier Precautions.

Review of the care plan for Resident #43 dated with a focus on the resident required to provide nutrition and hydration due to , , . The resident is at risk for loss and due to tube status and was recently hospitalized s/p and . Other conditions that could impact the resident's nutritional status include diagnoses of 's , , , and , . The goals were for the resident to have no significant change in the next 30 and 180 days, will have no s/s

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 880	Continued From page 29 , , will have no s/s of , or choking and will have no N/V/C/D (/ / , /) related to . by the next review date. The interventions included in part the following: Provide resident with feeding as ordered by my Medical Doctor (MD). Provide flushes as ordered by my MD. Family has preference for Jevity products. On at 2:18 PM, an observation was made of Staff A, Licensed Practical Nurse (LPN), who entered the room of Resident #43 to connect to the resident. Staff A did not wear a gown, but only wore gloves. Staff A connected the to the resident's and turned on the . During an interview conducted on at 2:25 PM with Staff A who was asked if Resident #43 was on Enhanced Barrier Precautions, she said yes because he has a . When asked what Personal Protective Equipment needed to be worn, she said gown and gloves. When asked why she did not wear a gown when connecting the , she said because she was only connecting the . 2. During a medication administration (Med Pass) observation conducted on at 6:05 PM with Staff D, Registered Nurse (RN), stated she has worked at the facility for a month. She dispensed the medications into a small medication cup and stated that the resident gets her medications crushed with apple sauce. Staff D then donned clean gloves, without performing hygiene, and poured the medication tablets into a pouch (except for a medication capsule) and crushed the medications and poured them	F 880		

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 880	Continued From page 30 into another cup. She threw away the pouch and removed the gloves, without performing hygiene, donned clean gloves and grabbed the medication capsule and stated that she squeezes the medication because the resident cannot swallow the capsule. After 15 seconds of squeezing the capsule, Staff D was able to pop the capsule and liquid got on her gloves and some in the medication cup. She then removed her gloves and discarded them and the shell of the capsule in the garbage. Without performing hygiene, she continued to prepare the medications. An interview was conducted with Staff D following the medication administration observation. She stated she realized she should perform hygiene more often during the Med Pass observation. During an interview conducted on at 6:50 PM with the Director of Nursing (DON), the surveyor discussed the medication administration observation. She was upset and stated that they have recently reviewed medication administration and washing. The DON acknowledged that there will be lots of education and training scheduled.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-	F 919		

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 919	Continued From page 31 §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure bathrooms are adequately equipped to allow residents / staff / visitors to call for staff assistance through a communication system for 4 of 73 bathrooms in the facility. The findings included: Review of the facility's policy titled, "Call Light, Responding" with a revised date of , included in part the following: "The call bell system will be checked routinely by maintenance for proper functioning." On at 10:36 AM, an observation was made of the emergency pull cord wrapped around grab bar in bathroom next to Oasis Kitchen and was unable to be activated by pulling on the cord. On at 10:55 AM, an observation was made of the emergency pull cord wrapped around grab bar in bathroom in and was unable to be activated by pulling on the cord. On at 10:59 AM, an observation was made of the emergency pull cord wrapped around grab bar in bathroom in and was unable to be activated by pulling on the cord. On at 11:02 AM, an observation was made of the emergency pull cord wrapped around grab bar in bathroom next to Social Worker office and was unable to be activated by pulling on the cord.	F 919	The statement made on this Plan of Correction are not and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulation the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Immediate Corrective Action: Call system were unwrapped from the grab bar in the residents□ bathroom immediately. Identification of other residents potentially affected: Current residents have the potential to be affected; however, based on inspection no residents were affected. Call light strings in residents□ bathroom were inspected throughout the units to ensure compliance with resident call system. No other resident call system was identified out of compliance. Measures: On , team members were re-educated on ensuring the call system cord is not wrapped around a grab bar. The call system must be adequately equipped to allow residents to call for staff assistance through a communication system. Inservice will be completed for newly hired team members.	

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

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F 919	Continued From page 32 On at 8:45 AM, a second observation was made of the emergency pull cord wrapped around grab bar in bathroom next to Social Worker office and was unable to be activated by pulling on the cord. On at 10:30 AM, a second observation was made of the emergency pull cord wrapped around grab bar in bathroom next to Oasis Kitchen and was unable to be activated by pulling on the cord. On at 9:10 AM, a second observation was made of the emergency pull cord wrapped around grab bar in bathroom in and was unable to be activated by pulling on the cord. On at 9:40 AM a second observation was made of the emergency pull cord wrapped around grab bar in bathroom in and was unable to be activated by pulling on the cord. On at 9:42 AM, a third observation was made of the emergency pull cord wrapped around grab bar in bathroom next to Oasis Kitchen and was unable to be activated by pulling on the cord. During a tour of the facility conducted on at 12:00 PM with the Maintenance Tech and the Administrator, they acknowledged the emergency pull were wrapped around the grab bare in the bathroom next to the Oasis Kitchen and in . The bathroom next to the Social Worker office was locked and we were unable to enter at time of this tour. An interview was conducted on at 12:20 PM with Maintenance Tech who stated they will	F 919	Monitoring: The Director of Property Management and Maintenance Assistants will complete daily audits for 4 weeks and then weekly x two months to ensure compliance with resident call system standards. Director of Property management will report the findings to the Quality Assurance Performance Improvement Committee Monthly X 3 months or until committee determines substantial compliance.	

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	105355	A. BUILDING _____ B. WING _____	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT ST ANDREWS ESTATES	6152 N VERDE TRAIL BOCA RATON, FL 33433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 33 make sure they do rounds to consistently look for the emergency pull to ensure they are no emergency pull wrapped around the grab bars.	F 919		