PRINTED: 09/08/2016

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CENTERS FOR MEDICARE & MEDICAID SERVICES					MB NO.	0938-039
					(X3) DATE SURVEY COMPLETED	
F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING.		1 00	FLETED
	405240	B WING				0510040
	105219	B. WING			08/	25/2016
PROVIDER OR SUPPLIER						
ATON REHABILITATION	ON CENTER					
			В	<u> </u>		,
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION
REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
An unannounced F conducted on Boca Raton Rehab not in compliance v Requirements for L 483.20(k)(3)(ii) SEI PERSONS/PER C. The services provice must be provided by the conduction of the conduction of the provided by the conduction of the conducti	ecertification survey was through at illitation Center. The facility is with 42 CFR Part 483, ong Term Care Facilities. RVICES BY QUALIFIED ARE PLAN deed or arranged by the facility by qualified persons in					
	OF DEFICIENCIES OF CORRECTION	OF DEFICIENCIES (X1) PROVIDER SUPPLIER LA IDENTIFICATION NUMBER 105219 PROVIDER OR SUPPLIER ATON REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An unannounced Recertification survey was conducted on through at Boca Ration Rehabilitation Center. The facility is not in compliance with 42 CFR Part 483. Requirements for Long Term Care Facilities. 483.20(K)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	OF DEFICIENCIES (X1) PROVIDERSUPPLIERICLA (X2) MUIA BUILT (X2) MUIA BUILT (X2) MUIA BUILT (X3) MUIA BUILT (X3) MUIA BUILT (X3) MUIA BUILT (X3) MUIA BUILT (X4)	OF DEFICIENCIES (X1) PROVIDERSUPPLERICLIA (X2) MILITIP A BUILDING 105219 B. WING 105219 B. WING STORM REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS FOOD TO STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS FOOD TO STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) AN unannounced Recertification survey was conducted on through at Boca Ration Rehabilitation Center. The facility is not in compliance with 4 CFR Part 483, Requirements for Long Term Care Facilities. 483.20(K)(3)(f) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	OF DEFICIENCIES OF DEFICIENCIES OF ORDER OF SUPPLIER A BUILDING 105219 105218 1052	OF DEFICIENCIES (X1) PROVIDERS UPPLIER 105219 B. WING 105219 ROVIDER OR SUPPLIER ATON REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An unannounced Recertification survey was conducted on through through through the conducted on through at Boca Ration Rehabilitation Center. The facility is not in compliance with 42 CFR Part 483. Requirements for Long Term Care Facilities. 483.20(K(3)(M)): SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each residents written plan of

and effectiveness for a resident receiving anti-.......... medication.

The findings include:

1. Resident #116 was originally admitted to the , his most recent admission was His diagnosis include: , abnormal due to inhalation of food and posture, ... , type 2 , hemiplagia, major

This REQUIREMENT is not met as evidenced Based on interview and record review the facility

failed to provide services in accordance with the written care plan of 2 of 8 sampled residents.

evidenced by not following diet as ordered for

feeding, and not monitoring side effects

(Resident #116 and Resident #142), as

A review of Resident #116's physician order sheet

, aphasia followed by

care plans. 4. DON or designee will audit care plans weekly x 4 weeks

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

unspecified

medications were

1 and

Preparation, submission and or execution of this Plan of Correction does not

constitute admission or agreement by the provider of the truth of the items alleged

or conclusion set forth in the statement of

1. Care plans for resident #116 and #142

were reviewed and updated immediately.

3. Director of nursing/designee in-serviced

2. Care plans for residents receiving feeding were reviewed and

updated. Care plans for residents

reviewed and updated.

nurses on updating

deficiencies. The Plan of Correction is

prepared and executed as required by State and Federal law.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that Any outcourcy statement enural was an asterias () destrose a deficiency writtn the institution the institution may be excused from ordered provious in a deaffairful of the safeguards provide sufficient protection to the patients. (See institutions). Except for nursing homes, the findings stated above are disclosed 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 disclosed to days following the date these documents are made evaluable to the readility. If deficientless are cited, an approved plan of correction is requisite to confined. program participation.

receiving

and

PRINTED: 09/08/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A BUILDING
(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X4) MULTIPLE CONSTRUCTION
A BUILDING
(X5) DATE SURVEY COMPLETED

(X6) DATE SURVEY COMPLETED

(X7) MULTIPLE CONSTRUCTION
(X8) DATE SURVEY COMPLETED

(X8) MULTIPLE CONSTRUCTION
(X9) DATE SURVEY COMPLETED

(X9) DATE SURVEY COMPLETED

(X9) MULTIPLE CONSTRUCTION
(X9) DATE SURVEY COMPLETED

(X9) DATE S

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

	PROVIDER OR SUPPLIER	755 MEADOWS ROAD		
BOCA R	ATON REHABILITATION CENTER		BOCA RATON, FL 33486	
(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)	COMPLETIO DATE
F 282	Continued From page 1 reveals an feed order dated Diabetisource 350 ml via tube (Endoscopic) total of 2100 ml. A review of the care plan dated for Resident #116 reveals a nutritional problem related to weight loss with interventions to include	F 28	and then random audits monthly x 3 months or until such time substantial compliance has been met. Findings will be reported QAPI.	
	"Diet as ordered". A review of the Medication Administration Record for at 10:35 AM revealed that Resident #116 receives feed very 4 hours Diabetisource 350 ml via tube total 2100 ml at 0100, 0500, 0900, 1300, 1700, 2100 and the record reflected that the resident received the entral feed on at 0100,0500 and 0900.			
	In an interview conducted with Staff H, a Licensed Practical Nurse (LPN) on at 10:30 AM she states she gives the resident the feed and it was recently changed to every 4 hours. She confirmed that she had not given Resident #116 the feed today. She stated she gave him all his medications, but got busy and was not able to get back to him within her 1 hour time frame, and confirmed that she had documented the MAR as having given him the tube feeding prior to doing so.			
	In an interview conducted on at 10:46 AM with the Director of Nursing, she was present during the interview with the LPN and confirmed the findings.			
	Resident #142 was originally admitted to the facility on his latest re-admission was on			

PRINTED: 09/08/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

A. BUILDING _

105219 B. WING _ NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

755 MEADOWS ROAD

BOCA RATON REHABILITATION CENTER			755 MEADOWS ROAD BOCA RATON, FL 33486			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG				
F 282	Continued From page 2 bi-polar and muscle A review of Resident #142's physician order sheet for revealed medications the resident is currently receiving include: tablet 0.5 mg at bedtime, ordered ER 15 mg every 12 hours, ordered tablet 20 mg once a day, ordered 25 mg every 12 hours, ordered 40 mg tablet once a day, ordered 40 mg tablet once a day, ordered A review of Resident #142's Medication Administration Record (MAR) and clinical record from Intrough lacked any documentation of monitoring for the and for behavioral disturbances, side effects and agitation. A review of Resident # 142's care plan dated and revised on revealed a Focus of medication, with interventions to include: Administer medications as ordered. Observe/document for side effects and effectiveness. In an interview conducted on 10:51 AM with Staff K, a Licensed Practical Nurse (LPN) she states that she is Resident #142's medications he is receiving.	F2				
	In an interview conducted on at 10:55 AM with Staff L, Registered Nurse Unit manager					

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING _ 105219 B. WING 08/25/2016 STREET ADDRESS CITY STATE 7ID CODE

MAKE OF BROWNER OR SURRI IEE

OCA R	ATON REHABILITATION CENTER	1	MEADOWS ROAD CA RATON, FL 33486	
(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 282	Continued From page 3 monitoring for any of the medications Resident #142 is receiving.	F 282		
	In an interview conducted on it at 10:57 AM with the Risk Manager, she confirmed that they are currently not monitoring for any of the medications Resident #142 is receiving, but corrected the MAR immediately to begin monitoring for behaviors, and side effects.			
	In an interview conducted on at 11:28 AM with the Consultant Pharmacist he states that there should be monitoring for behaviors for the and and, and confirmed that the facility added the behavior monitoring on			
	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		
	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate): or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.			
	Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used drugs are not given these drugs unless drug is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use drugs receive gradual dose reductions, and			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR EDICARE & MEDICAID SERVICES

PRINTED: 09/08/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
DENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A BUILDING

(X3) DATE SURVEY
COMPLETED

(X3) DATE SURVEY
COMPLETED

(X4) PROVIDER/SUPPLIER/CLIA
DENTIFICATION NUMBER:

(X5) DATE SURVEY
COMPLETED

(X6) DATE SURVEY
COMPLETED

(X7) DATE SURVEY
COMPLETED

(X6) DATE SURVEY
COMPLETED

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COMPLETED

(X8) DATE SURVEY
COMPLETED

(X9) DA

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
BOCA R	ATON REHABILITATION CENTER		755 MEADOWS ROAD			
DOOR INTO IN TELEPORATION OF THE PARTY OF TH			BOCA RATON, FL 33486			
(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 329	Continued From page 4 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329				
	This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide adequate monitoring for 1 of 5 sampled residents reviewed for unnecessary medications (Resident # 142), as evidenced by not monitoring a resident # 142), as evidenced by not monitoring a resident that is receiving an anti-medication. The findings include: Resident #142 was originally admitted to the facility on his latest re-admission was on His diagnoses include: Parkinson's bi-polar and muscle A review of Resident #142's physician order sheet for revealed that the resident is currently receiving the following medications: tablet 0.5 mg at bedtime, ordered tablet 20 mg once a day, ordered 25 mg every 12 hours, ordered 40 mg tablet once a day, ordered		1. Resident #142 has monitoring in place at this time. 2. Medication Administration Records for residents receiving medications have been reviewed and updated to include monitoring resident's behavior and side effects and effectiveness for a resident receiving an medication. 3. Director of nursing/designee in-serviced nurses on updating Medication Administration Records for residents receiving medications to include behavior monitoring and side effects. 4. DON or designee will audit Medication Administration Records for residents receiving medications for behavior monitoring and side effects weekly x 4 weeks and then monthly x3 months or until such time substantial compliance has been met. Findings will be reported to QAPI.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

PRINTED: 09/08/2016 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X2) MULTIPLE CONSTRUCTION A. BUILDING

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

08/25/2016

105219

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

755 MEADOWS ROAD BOCA RATON REHABILITATION CENTER BOCA RATON, FL 33486 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION DATE (X4) (D (EACH CORRECTIVE ACTION SHOULD BE (EACH DESIGNECY MUST BE PRECEDED BY FULL PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 329 Continued From page 5 F 320 A review of Resident #142's Medication Administration Record (MAR) and clinical record lacked any from through documentation of monitoring for the and for behavioral disturbances, side effects and agitation. A review of Resident # 142 's care plan dated and revised on revealed a medication, with interventions to include: Administer medications as ordered. Observe/document for side effects and effectiveness. In an interview conducted on AM with Staff K, a Licensed Practical Nurse (LPN) she states that she is Resident #142 's assigned nurse today, and confirmed that he is not currently being monitored for any of the medications he is receiving. She further stated that all the monitoring is documented on the MAR. at 10:55 In an interview conducted on AM with Staff L. Registered Nurse Unit manager she confirmed that they are currently not monitoring for any of the medications Resident #142 is receiving. He had been previously been monitored for the medications, but since he was readmitted on the monitoring was not put back on the MAR, for documentation. In an interview conducted on 10:57 AM with the Risk Manager, she confirmed that they are currently not monitoring for any of medications Resident #142 is

PRINTED: 09/08/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE &EDICAID SERVICES

STATEMENT OF DEFICIENCES
AND PLAN OF CORRECTION

(X1) PROVIDERSUPPLENCIA
AD ULITIFIC CONSTRUCTION
A BUILDING
B. WING

O8/25/2016

STREET ADDRESS, CITY, STATE, ZIP CODE

OCA R	ATON REHABILITATION CENTER		755 MEADOWS ROAD BOCA RATON, FL 33486		
(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) COMPLETI DATE	
F 329	Continued From page 6 receiving, but corrected the MAR immediately to begin monitoring for behaviors, agitation behaviors, and side effects.	F 329			
	In an interview conducted on at 11:28 AM with the Consultant Pharmacist he states that there should be monitoring for behaviors for the and , and confirmed that the facility added the behavior monitoring on				
F 514 SS≃D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE	F 514			
	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented; readily accessible; and systematically organized.				
	The clinical record must contain sufficient information to identify the resident, a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State, and progress notes.				
	This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that medication administration record (MAR) was accurately documented for 1 of 3 residents reviewed for tube feeding (Resident #116). As evidenced by documenting the MAR prior to administering the tube feeding.		Nursing staff member #H was in-serviced immediately not to sign the Medication Administration Record until after nutrition is administered. Director of nursing and risk manager did visual random audit of nurses.		

when it had not yet been administered.

performing medication administration to ensure accurate documentation was

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X2) PROVIDER/SUPPLIER/CLIA
DENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A BUILDING

(X3) DATE SURVEY
COMPLETED

(X3) DATE SURVEY
COMPLETED

(X6) MULTIPLE CONSTRUCTION
(X7) MULTIPLE

	105219		B. WING			08/25/2016	
NAME OF PROVIDER OR SUPPLIER BOCA RATON REHABILITATION CENTER				REET ADDRESS, CITY, STATE, ZIP CODE 5 MEADOWS ROAD			
		BOCA RATON, FL 33486					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 514	facility on On His did due to inhalation of posture, major Unspecified A review of Reside reveals an Diabetisource 350 ml. A review of the Me for at 10: #116 receives Diabetisource 350 at 0100, 0500, 090 record reflected the entral feed on In an interview cor Practical Nurse (LI AM she states she feed and it was reviews. She confirm Resident #116 the hour time frame, a documented the N tube feeding prior In an interview cor In an interview c	originally admitted to the his most recent admission was gnosts include: food and abnormal, type 2 hemiplagia, aphasia followed by hemiplagia, aphasia followed by the first physician order sheet feed order dated for mil via tube, total of 2100 dication Administration Record 35 AM revealed that Resident I feed every 4 hours mil via tube total 2100 mil 0, 1300,1700,2100 and the at the resident received the at 0100,0500 and 0900. ducted with Staff H, a Licensed PN) on at 10.300 gives the resident the eventy changed to every 4 eventy changed to every 4 eventy changed to every 4 eventy changed to be open at 10.300 gives the resident the sendications, but got busy to get back to him within her 1 and confirmed that she had laR as having given him the to doing so.	F5	14	completed. 3. Director of nursing/designee in-sen nurses on accurate documentation o Medication Administration Record. 4. DON or designee will audit Medication Administration Records x weeks and then monthly x3 or until time substantial compliance has bee met. Findings will be reported to QAF	4 uch	

present during the interview with the LPN and

PRINTED: 09/08/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED A. BUILDING 105219 B. WING 08/25/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 755 MEADOWS ROAD BOCA RATON REHABILITATION CENTER BOCA RATON, FL 33486 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID (X5) COMPLETION DATE (X4) ID PREFIX TAG TAG DEFICIENCY) F 514 Continued From page 8 F 514 confirmed the findings.

Event ID: 7G1G11

Facility ID: 95003

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 9 of 9

Agency f	or Health Care Adm	inistration			FORM A	PPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		95003	B. WING		08/25	/2016
NAME OF F	ROVIDER OR SUPPLIER			TATE, ZIP CODE		
BOCA RA	TON REHABILITATION		OWS ROAD TON, FL 334			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
N 000	INITIAL COMMEN	rs	N 000			
	conducted on	telicensure survey was through at illitation Center. The facility had time of the visit.	th Annual Control			
	400.141(1)(j), FS; 5 Medical Records	59A-4.118(2), FAC Resident	N 101			
-	discharges; medical including medical history, and identify other persons who affairs of the reside care plans, includir prescribed services duration, and services duration, and service accordance with a and practices, while	f resident admissions and al and general health status, ecords, personal and social vand address of next of kin or may have responsibility for the nt; and individual resident g, but not limited to, s, service frequency and ce goals. The records must be pection. The licensee shall cords on each resident in coepled professional standards th must be complete, mited, readily accessible, and nized.				
	information to clea	rd must contain sufficient rly identify the resident, his or treatment, and results				
	Based on record re failed to ensure the record (MAR) was of 3 residents revie (Resident #116). A the MAR prior to a	le is not met as evidenced by: eview and interview the facility at medication administrations accurately documented for 1 ewed for tube feeding as evidenced by documenting dministering the tube feeding, t been administered.	Programme and the company of the com	Preparation, submission and or e of this Plan of Correction does no constitute admission or agreeme provider of the truth of the items conclusion set forth in the statem deficiencies. The Plan of Correct prepared and executed as requir State and Federal law.	ot nt by the alleged or ent of ion is	

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed STATE FORM

7G1G11

If continuation sheet 1 of 5

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER:SUPPLIERCUA IDENTIFICATION NUMBER: A BUILDING:

95003 B. WING 08/25/2016

	95003		1 00/2	3/2010
NAME OF			STATE, ZIP CODE	
BOCA R		TON, FL 334		
(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) COMPLETE DATE
N 101	Continued From page 1	N 101		
	The findings include: Resident #116 was originally admitted to the facility on his most recent admission was on His diagnosis include: due to inhalation of food and abnormal posture, type 2 hemiplagia, major , aphasia followed by unspecified A review of Resident #116's physician order sheet reveals an feed order dated for Diabetisource 350ml via tube, total of 2100 A review of the Medication Administration Record for at 10:35 AM revealed that Resident #116 receives feed every 4 hours Diabetisource 350 ml via tube total 2100 ml at 0100, 0500, 0900, 1300, 1700, 2100 and the record reflected that the resident received the entral feed on at 0100,0500 and 0900. In an interview conducted with Staff H, a Licensec Practical Nurse (LPN) on AM she states she gives the resident the feed and it was recently changed to every 4 hours. She confirmed that she had not given Resident #116 the feed today. She stated she gave him all his medications, but got busy and was not able to get back to him within her 1 hour time frame, and confirmed that she had documented the MAR as having given him the tube feeding prior to doing so. In an interview conducted on at 10:46 AM with the Director of Nursing, she was present during the interview with the LPN and		1. Nursing staff member #H was in-serviced immediately not to sign the Medication Administration Record until after Inutrition is administered. 2. Director of nursing and risk manager did visual random audit of nurses performing medication administration to ensure accurate documentation was completed. 3. Director of nursing/designee in-serviced nurses on accurate documentation on the Medication Administration Record. 4. DON or designee will audit Medication Administration Records weeks and then monthly x3 or until such time substantial compliance has been met. Findings will be reported to QAPI.	

AHCA Form 3020-0001

confirmed the findings.

STATE FORM

If continuation sheet 3 of 5

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

| (X1) PROVIDERSUPPLERICLIA | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY | (X3) DATE SURVEY | (X4) MULTIPLE CONSTRUCTION | (X4) MULTIPLE CONSTRUCTION | (X4) MULTIPLE CONSTRUCTION | (X4) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY | (X4) MULTIPLE CONSTRUCTION | (X4) MULTIPLE CONSTRUCTION | (X4) MULTIPLE CONSTRUCTION | (X5) MULTIPLE CONSTRUCTION | (X6) MULTIPLE CONSTRUCTION | (X7) MULTIPLE CONSTRUCTION

	95003	0.11.11	1 00	23/2010
NAME OF F	PROVIDER OR SUPPLIER STREET AL	DRESS, CITY, ST	ATE, ZIP CODE	
BOCA RA	TON PEHABII ITATION CENTER	DOWS ROAD	_	
	BUCARA	ATON, FL 3348	PROVIDER'S PLAN OF CORRECTION	(20)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
N 101	Continued From page 2	N 101		
	Class III			
	435.12(2)(b-d), FS Background Screening Clearinghouse	NZ814		
	435.12(2) Care Provider Background Screening Clearinghouse. (b) Until such time as the fingerprints are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with the citarinnal history checks through the clearinghouse before referring an employee or potential employee for electronic fingerprint submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name, social security number; date of birth; mailing address;; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtair a social security number must provide an individual taxpayer identification number.			
	This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to register all		Employees F, G, H, and I have been registered with background screening	

AHCA Form 3020-0001 STATE FORM

7G1G11

Agency	for Health Care Adm	inistration				APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		95003	B. WING		08/2	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BOCA R	ATON REHABILITATIO	ON CENTER	TON, FL 334			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
NZ814	Continued From pa	ige 3	NZ814			
	the employment state clearinghouse for 4 records reviewed. (The findings includ Review of the clear conducted on employee records and I), indicated the 4 employees in within the clearingh A review of the faci the following: A review of the faci the following: A review of the faci the following: 1) Employee F hais employed as a C 2) Employee A as a C 3) Employee as a C and is employed as a C 4. All 4 employees had is employed as a C and is employee backgrown and interview corwith the Payroll Be confirmed that she employee backgromaintenance of the	inghouse employee roster revealed that 4 of the 10 reviewed (Employees F, G, H at the facility had not registered the facility had not restricted. It is a made that the facility had not had		clearinghouse. 2. Employee records have been registered wit background screening clearingho and staff have been registered wit background screening clearinghouse. 3. Administrator/designee in-servi administrative staff on entering state employee background screen clearinghouse. 4. Administrator or designee will a employee records x 4 weeks and monthly x3 or until such time subscompliance has been met. Finding reported to QAPI.	th use, ced aff into ing udit new then stantial	

STATE FORM

In an interview conducted with the Administrator on ... at 3:20 PM, she confirmed that she is aware of the regulation, but had not instructed the Payroll Benefits Coordinator on the regulation and AHCA Form 3020-0001 if continuation sheet 4 of 5 7G1G11

Agency	for Health Care Adm	inistration			FORM APPROVED	
STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		95003	B. WING	<u>:</u>	08/25/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BOCAR	ATON REHABILITATI		ADOWS ROAI ATON, FL 33			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETE	
NZ814	Continued From pa	age 4	NZ814			
	confirmed the findi	ngs.				
	Unclassified					
					Į	
AHCA Form			cope	7G1G11	If continuation sheet 5 of	



RICK SCOTT GOVERNOR

ELIZABETH DUDEK SECRETARY

Administrator Boca Raton Rehabilitation Center 755 Meadows Road Boca Raton, FL 33486

RE: Recertification, Relicensure & Life Safety Code

Dear Administrator:

On ______, 2016 through _____, 2016, Recertification, Relicensure and Life Safety Code surveys were conducted in your facility by representatives of this office.

The purpose of this visit was to determine if your facility was in compliance with requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found not in substantial compliance with the participation requirements.

Enclosed are the provider's copies of Form CMS-2567 (Statement of Deficiencies and Plan of Correction) and State (3020) Form. These forms reference the deficiencies that were identified during the visit. You will not receive a copy of this letter and attachments in the mail; you will only receive this electronic report.

A Plan of Correction (POC) for the deficiencies must be submitted to this Field Office 10 days after your facility receives the faxed Form CMS-2567. Failure to submit an acceptable POC within ten (10) days after receipt of the faxed statement of deficiencies may result in the imposition of remedies. You will be notified by telephone or fax if your POC is found to be acceptable. If your POC is found to be unacceptable, you will be informed in writing. The correction date indicated by the facility shall be after the date of survey exit. **Deficiencies shall be corrected no later than**, 2016.

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systematic changes you will make to
 ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Delray Beach Field Office 5150 Linton Boulevard, Suite 500 Delray Beach, FL Phone (561) 381-5840; Fax:(561) 496-5924 AHCA.MyFlorida.com



Recommended Remedies:

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other sanction is warranted, we will provide you with a separate formal notification of that determination.

Remedies will be recommended for imposition by CMS if your facility has failed to achieve substantial compliance by the revisit. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the noncompliance found may result in a change in the remedy recommended. When this occurs, you will be advised of any change in remedy.

- Civil Money Penalty, in an amount and duration to be determined by CMS.
- A mandatory denial of payment for new admissions will be imposed substantial compliance is not achieved by that time. Termination of Medicare Agreement. We are recommending to the CMS Regional Office
- and/or State Medicaid Agency that your provider agreement be terminated on 2017 if substantial compliance is not achieved by that time.

. 2016 if

If, upon the subsequent revisit, your facility has not achieved substantial compliance, the CMS Regional Office or State Medicaid Agency will impose the other remedies indicated above, or a revised remedy, if appropriate.

Informal Dispute Resolution:

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Attention: IDR Coordinator Agency for Health Care Administration 2727 Mahan Drive, Mail Stop 9-A Tallahassee, Florida 32308 FAX (850) 414-6946 or

Phone number: (850) 412-4301 IDRCoordinator@ahca.myflorida.com

The IDR request must be sent during the same 10 days you have for submitting a Plan of Correction for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Boca Raton Rehabilitation Center 2, 2016 Page 3

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representatives. If you have questions, please contact this office at (561) 381-5840.

Sincerely,

Maryanne Salerni for-Arlene Mayo-Davis Field Office Manager

AMD Enclosure

R6WB