Agonou fe	or Health Care Adminis	tration			PRINTED: 03 FORM API	
STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		95003	B. WING		C 02/26/20	019
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
BOCA RA	TON REHABILITATION C	ENTER	ADOWS ROAD RATON, FL 3348			
	CURRANDVCT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) OMPLETE DATE
N 000	INITIAL COMMENTS		N 000		aranasana an	
	CCR # 2019002340, at Boca Raton Rehab 1054096. The allegat	nsure complaint survey, was conducted on illitation Center, License ions were substantiated. iencies at the time of the				
N 201 SS=D	400.022(1)(I), FS Rigi Appropriate Health Ca		N 201			
	health care and prote including social servic if available; planned r therapeutic and rehat with the resident care recognized practice s	dequate and appropriate ctive and support services, rese; mental health services, ecreational activities; and slittative services consistent plan, with established and tandards within the rules as adopted by the				
	Based on observation review, the facility fail nutritional and hydrati assist with feeding for Residents (Resident). The findings included	*1). :		Preparation, submission and or exect of this Plan of Correction does not constitute admission or agreement by provider of the truth of the items alleg conclusion set forth in the statement of deficiencies. The plan of cor	the ed or of	
	was admitted on at 1:42 PM. , legal Physician on Monday, Wednesor record review shower Review of the state of	1 record showed that she and discharged on Diagnoses included,		Resident #1 has been discharged DON/Designee audited current residents to ensure nutrition assessm timely vision and assistance with eating are appropriate SDC/designee in-serviced nurses ensure is obtained on admissial and admission assessments are	ent, o. s to	

AHCA Form 3020-0001

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

(X6) DATE TITLE Electronically Signed /19

STATE FORM If continuation sheet 1 of 4 Y7NV11

n PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 95003	1 ' '	CONSTRUCTION		
DENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		urv
95003	A BUILDING:		(X3) DATE SURV COMPLETE	
95003				
95003			С	
	B. WING		02/26/2	2019
STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
R	OWS ROAD			
" BOCA RAT	ON, FL 33486			
NT OF DEFICIENCIES BE PRECEDED BY FULL INTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE I	(X5) COMPLETE DATE
	N 201		manana	
ating by) and is Admission Data Admission Data a thowed that Resident verely at 8:30 PM with er, he reported that a resident with her that Resident #1 is to see at all including the told the facility's sistance with all sisted under tent #1 is NPO. Under by Living (ADL) it with assist of 1 and is Further review of the more on vision Minimum Data Set on G for eating seech Language 10:50 AM, she vasa admitted to the hen asked if she was		assistance with meals. DON/designee in-serviced RD to assess new admiss to ensure are recorded in PCt and diet is accurate. DON/designee will audit new admissions to ensure nutrition assessment, diet order is accurate and vision is identified. Audits will be completed we for 4 weeks then monthly for 3 months DON will present audit results monthly	ions C rekly s.	
	interpretation of the process of the	TERPRECEDED BY FULL NTEYPING INFORMATION) N 201 Inting by) and is Admission Data howed that Resident verely at 8:30 PM with er, he reported that resident in the resident with her that Resident #1 is to see at all including in the total the facility's ssistance with all sistend under lent #1 is NPO. Under ly Living (ADL) it with assist of 1 and is Further review of the on on vision Minimum Data Set on G for eating seech Language 10:50 AM, she was admitted to the hen asked if she was	rise PRECEDED BY FULL NTIFYING INFORMATION) N 201 ating by) and is Admission Data throwed that Resident verely . at 8:30 PM with er, he reported that e health with her that Resident #1 is to see at all including the told the facility's sistance with all ating determine the resident with the relation of the relat	Tag PRECEDED BY FULL NTEYPING INFORMATION) N 201 appropriate related to NPO, vision and assistance with meals. DON/designee in-serviced RD to assess new admissions to ensure _ are recorded in PCC and diet is accurate. - DON/designee will audit new admissions to ensure _ are recorded in PCC and diet is accurate. - DON/designee will audit new admissions to ensure _ are recorded in PCC and diet is accurate. - DON/designee will audit new admissions to ensure _ are recorded in PCC and diet is accurate. - DON/designee will audit new admissions to ensure untrition assessment, _ diet order is accurate and vision _ is identified. Audits will be completed weekly for 4 weeks then monthly for 3 months. DON will present audit results monthly at Performance improvement meeting for three months then as indicated. Performance improvement meeting for three months then as indicated.

76%-100% for lunch and dinner. Intake of meals AHCA Form 3020-0001

SLP further stated that Resident #1 came in on a pureed diet with nectar thick liquids. An evaluation done by the SLP showed that she was safe to tolerate pureed diet with thickened liquids. Review of the Certified Nursing Assistant percentage of meals intake the following were noted: intake for was at 26%-50% for breakfast, 51%-75% for lunch, and 76%-100% of dinner. Meal intake for was noted at

STATE FORM caso Y7NV11 If continuation sheet 2 of 4 Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С 95003 B. WING ____ 02/26/2019

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CA RA	CA RATON REHABILITATION CENTER 5755 MEADOWS ROAD 500C RATON, FL 33486							
X4) ID REFIX 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 201	Continued From page 2	N 201		- Control of the Cont				
	for at 8:17 PM was noted at 51%-100%. Resident was discharge on at 1:43 PM.							
	In an interview with the DON on at 2:00 PM, she acknowledged the discrepancies in the documentation.			in the state of th				
	In an interview with Staff A, (CNA) on at 12:20 PM, she reported that Resident #1 did not need assistance with eating. She further stated that Resident #1 was able to eat by herself with no issues. When asked by surveyor if Resident #1 had vision problems she said no.							
	In an interview with Staff B, on at 1:00 PM, she reported that she makes her decision regarding section G of the Minimum Data Set (MDS) for eating from the CNA documentation. She further observes the Resident herself but since Resident #1 was discharge from the facility she did not see the Resident.							
	Review of the Communication tool showed no communication sheet or taken for Resident #1 in the binder. Further review of the facility's policy for management showed that are completed upon admission and readmission for 4 weeks then monthly.							
	In an interview with Staff C, CNA, on at 10:38 AM, she reported that all Residents are taken upon admission. When asked why Resident #1's was not taken upon admission she did not know.			andandario dandario d				
	In an interview with Staff D on			normal de la companya				

AHCA Form 3020-0001

PRINTED: 03/13/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING 95003 02/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 755 MEADOWS ROAD BOCA RATON REHABILITATION CENTER BOCA RATON, FL 33486 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 | Continued From page 3 N 201 sheet was missing but she did contact the . . , . . center to obtain the _____ treatment dated Surveyor voiced concerned as to the importance of ____, for ___, Residents. In an interview conducted with Staff F on at 1:50 PM, she reported that according to their policy she has up to 14 days to complete a nutritional assessment. When asked by surveyor if Resident #1 is considered a high risk Resident she said yes. Review of progress note dated at 1:42 PM showed that Resident #1 was found unresponsive with ____ noted at 38. Emergency 911 was called and the Resident was transfered to the hospital. Class III

AHCA Form 3020-0001

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/13/2019 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPL(ER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
		105219	B. WING			1	C /26/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BOCA BA	TON REHABILITATION O	CENTED		75	5 MEADOWS ROAD		
BUCAKA	TON REHABILITATION C	ENIER		В	DCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	2019002340, was co Raton Rehabilitation substantiated. The fa with 42 CFR Part 483 Term Care Facilities.	Center. The allegations were cility is not in compliance 3, Requirements for Long					
	Nutrition/Hydration S CFR(s): 483.25(g)(1)		F	692			
	(Includes naso- both endoso	d on a resident's ssment, the facility must					
	of nutritional status, si desirable body balance, unless the re	range and electrolyte esident's clinical condition s is not possible or resident					
	§483.25(g)(2) Is offer maintain proper hydro	red sufficient fluid intake to ation and health;					
	there is a nutritional provider orders a the	red a therapeutic diet when problem and the health care rapeutic diet. Tis not met as evidenced					
	Based on observation review, the facility fail				Preparation, submission and or exec of this Plan of Correction does not constitute admission or agreement by provider of the truth of the items alleg or conclusion set forth in the statemen	the ed	
AROBATORY	DIDECTOR'S OF BROVINSON	SLIPPLIER REPRESENTATIVES SIGNATURE	<u> </u>	_	TIFLE		(XIO DATE

Any deficiency statement ending with an asteriak (1) 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 disclossable 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 disclossable 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 prooram participant.

Electronically Signed

/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/13/2019 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						APPROVED
						0. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		LETED
		105219	B. WING			26/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			1 7	55 MEADOWS ROAD		
BOCA RA	FON REHABILITATION C	ENTER		BOCA RATON, FL 33486		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 692	was admitted on at 1:42 PM. , legal , Physician on Monday, Wedness' record review shower for exercif review of the under eating Resident #1 is NPO. Collection dated #1 is NPO, and vision in a phone interview of Resident #1 is Trailly in the facility did not assmeals. He further replegally and is no colors. According to staff that his sister ne meals. Review of the care pin nutrition showed that the section Activities a showed that Resident dependent on staff to care pina showed no staff to care pina sh	I record showed that she and discharged on Diagnoses included, dependence of type 2, and type 3, and type 3, and type 4, and t	F 692	deficiencies. The plan of correction is prepared and executed as required in State and Federal law. F692 NUTRITION HYDRATION STAMAINTENANCE Resident #1 has been discharge. DON/Designee audited current residents to ensure nutrition assess timely vision an assistance with eating are approprial so SDC/designee in-serviced nursensure is obtained on admission assessments are appropriate related to NPO, vision assistance with meals. DON/designe in-serviced nursensure are recorded in Pt and det is accurate. DON/designee will audit new admissions to ensure nutrition assessment, diet order is accurate and vision is accurate and vision is accurate and vision in control of the completed of for 4 weeks then monthly for 3 mont DON will present audit results month? Performance Improvement meeting three months then as indicated.	by ATUS and ment, didite. by the session of the sessions of	

Pathologist on at 10:50 AM, she

Facility ID: 95003

PRINTED: 03/13/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBER

		OMB NO. 0938-039
CLIA ER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED

		l		-
	105219	B. WING		02/26/201
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
DOGA DATON DELIADII ITATION OFNITED			755 MEADOWS ROAD				
BOCA RATON REHABILITATION CENTER			BOCA RATON, FL 33486				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION	(X5)			

BOCA RATON REHABILITATION CENTER			755 MEADOWS ROAD				
DOURINA	TON NEIDOLENATION CENTER		BOCA RATON, FL 33486				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 692	reported that Resident #1 was admitted to the facility from the hospital. When asked if she was NPO when she was admitted she said no. The SLP further stated that Resident #1 came in on a pureed diet with nectar thick flugids. An evaluation done by the SLP showed that she was safe to tolerate pureed diet with thickened liquids. Review of the Certified Nursing Assistant percentage of meals intake the following were noted: intake for was at 26%-50% for breakfast, 51%-75% for lunch, and 76%-100% of dinner. Meal intake for was noted at 75%-100% for lunch and dinner, Intake of meals for at 8:17 PM was noted at 51%-100%. Resident was discharge on at 1:43 PM. In an interview with the DON on at 2:00 PM, she acknowledged the discrepancies in the documentation. In an interview with Staff A, (CNA) on at 1:220 PM, she reported that Resident #1 did not need assistance with eating. She further stated that Resident #1 was able to abl by herself with no issues. When asked by surveyor if Resident #1 had vision problems she said no. In an interview with Staff B, on at 1:00 PM, she reported that she makes her decision. In an interview with Staff B, on at 1:00 PM, she reported that she makes her decision. She further observes the Resident herself but since Resident #1 was as able to all by herself with no issues. When asked by surveyor if Resident herself but since Resident #1 was as able to all by herself with no issues. When asked by surveyor if Resident herself but since Resident #1 was as able to all by herself with some Resident #1 was as able to all by herself with no issues. When asked by surveyor if Resident herself but since Resident #1 was as able to all by herself with some Resident #1 was as able to all by herself with since Resident #1 was as able to all by herself with since Resident #1 was as able to all by herself but since Resident #1 was as able to all by herself with since Resident #1 was able to all by herself with since Resident #1 was able to all by herself with since Resident #1 was able to al	Fi	592				
	Review of the Communication tool showed no communication sheet or taken for Resident #1 in the binder. Further						

Facility ID: 95003

PRINTED: 03/13/2019

		ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391	
			1					
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPL(ER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION			SURVEY	
1010101	Obtailerion	DENTI IONITON TONICEN.	A. BUILDING					
						С		
		105219	B. WING	_		02/	26/2019	
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
		FUTER		755 MEADOWS ROAD				
BUCA RA	TON REHABILITATION C	ENIER		BOCA RATON, FL 33486				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	_	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION	
TAG			TAG	TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(TE	DATE	
					SEPTORENCT)			
F 692	Continued From page	3	F	69	02			
	review of the facility's	policy for						
		that are completed						
		readmission for 4 weeks						
	then monthly.							
	In an interview with S	taff C, CNA, on at						
	10:38 AM, she reporte	ed that all Residents						
	are taken upon admis	ssion. When asked why						
	Resident #1's	was not taken upon						
	admission she did not							
	In an interview with S	taff D on at 11:20						
		t the communication ,						
	binder is always in the	e nurses station. She did not						
	know as to why Resid	dent #1's communication						
	sheet was missing bu							
		. , treatment dated						
		piced concerned as to the						
	importance of	for , Residents.						
	In an interview condu-							
		she reported that according						
		s up to 14 days to complete						
	a nutritional assessme							
		‡1 is considered a high risk						
	Resident she said yes	š.						
		ote dated at 1:42						
	PM showed that Resi							
		noted at 38.						
		called and the Resident was						
	transfered to the hosp	ла.						
			1				1	

Facility ID: 95003