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
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 000	Initial Comments An unannounced licensure Complaint (#2023013685) survey was conducted on at Boca Raton. The facility had a deficiency identified at the time of the survey.	A 000		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	A 030		

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
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 030	Continued From page 1 and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where	A 030		

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
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 030	Continued From page 2 residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from [illegible] and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as	A 030		

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
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 030	Continued From page 3 provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with	A 030		

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
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 030	Continued From page 4 relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility	A 030		

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
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 030	Continued From page 5 must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to initiate and perform , , ( ) on 1 of 1 sampled residents found unresponsive and who was a Full Code status, Resident #1. This failure has the potential to affect 54 of the 64 residents residing in the facility who exercised their right to be a Full Code status in the event they experience a , event.	A 030		

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
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 030	Continued From page 6 The findings included: Review of the facility's and Training Policy dated 11/08/13, documented the following: There must be documentation in the resident's record indicating whether he or she has executed a ( ). If a has been executed, a copy of that document must be made a part of the resident's record. If the community does not receive a copy of a resident's executed , the community must document in the resident's record that it has requested a copy. Our community's policy is to NOT withhold despite the presentation to us of a . All team members trained in are required to immediately initiate if no signs of life are present, regardless of status. Exception: Current hospice residents. In the event a resident experiences , call 911 and initiate . Appropriately trained nursing team members should follow 's Automated External Defibrillator ( ) policy for use as long as doing so does not disrupt the continuation of . Review of Resident #1's Resident Health Assessment (AHCA Form 1823) dated revealed she was admitted to the facility on with diagnoses to include , and . Under Physical/Sensory Limitations is documented Resident #1 was alert and able to make her needs known. Resident #1 required assistance with all activities of daily living with the exception of no assistance was required for eating. Further, Resident #1 exercised her	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 030	Continued From page 7 right to be a Full Code status if she suffered a , , event. Review of the Resident #1's facility Observation Notes revealed the following entries: On at 1:24 PM Licensed Practical Nurse (LPN) Staff N documented 'Resident #1 presented , appearing to have and complaining of not feeling well. Provider contacted and resident sent out to (name of local hospital).' No additional information or assessment was documented on Resident #1's Observation Notes at the time of this entry. On an entry by LPN (Staff N) on Resident #1's Observation Notes documented, 'Resident arrived from the hospital at 3:30 PM (via wheelchair van) with a diagnosis of acute , (,), , (related to the ,). Stated to be , had no appetite and no , . The facility's Wellness Director was notified of the resident's return.' On at 10:31 PM, an entry on Resident #1's Observation Notes by LPN (Staff M) documented, 'Resident had a poor appetite and fluids encouraged. The resident is said to have consumed 100% of (liquid) supplement with no reaction.' On at 1:23 PM, an entry on Resident #1's Observation Notes by LPN (Staff M) documented, 'Resident presented in bed, AAO (awake, alert, oriented), refusing to get out of bed, , c/o (complained of) feeling weak and tired, poor nutritional intake, refuses meals, states she does not have an appetite, 50% of nutritional supplement taken and tolerated. PCP	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 030	Continued From page 8 (Primary Care Physician), POA (Power of Attorney) and DRC (Director of Resident Care) are aware of resident's status.' No additional information or assessment was documented on Resident #1's Observation Notes at the time of this entry. On at 1:30 PM, an entry on Resident #1's Observation Notes by Wellness Director (Staff D) documented, 'Care staff reported resident was feeling unwell and did not have an appetite at lunch. VS WNL (vital signs within normal limits) at this time. Resident toileted and settled into bed per resident request.' No additional information or assessment was documented on Resident #1's Observation Notes at the time of this entry. On at 3:10 PM, an entry on Resident #1's Observation Notes by Wellness Director (Staff D) documented, 'Resident Care Assistant (RCA) Staff A in resident's room conducting rounds and observed resident unresponsive. RCA (Staff A) telephoned Wellness Nurse LPN (Staff C) to report she was with Resident #1 who was nonresponsive and not breathing. LPN went to the resident's room and observed Resident #1 lying on her left side in the bed and appeared grey blue with dark coming out her and . Resident #1 also had a large movement. The LPN did not touch, observe or provide to the resident. Resident #1 did not have a on file, was Full Code and no was performed by RCA (Staff A) or any facility staff.' In review, on at 3:15 PM, the Wellness Director (Staff D) who was not at facility, was notified via telephone by LPN (Staff C) of Resident #1's unresponsive status.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 030	Continued From page 9 Wellness Director (Staff D) directed LPN (Staff C) to begin immediately. A review of facility documents and interview with LPN (Staff C) revealed Resident #1 did not have a on file, was Full Code and no was performed by LPN (Staff C) or any facility staff when the resident was found to be unresponsive and not breathing. On at 3:16 PM, LPN (Staff C) who went to Resident #1's room, called 911. (Emergency Medical Services), along with Law Enforcement is said to have arrived at the facility at 3:20 PM. Resident #1 was pronounced at the facility by personnel. In an interview conducted on at 10:36 AM with the Administrator, the Regional Wellness Director and Wellness Director (Staff D), they stated was not performed on Resident #1. Wellness Director (Staff D) stated RCA (Staff A) called LPN (Staff E), and LPN (Staff E) called her. She stated LPN (Staff E) informed her of Resident #1's condition and asked her what they should do. She stated she informed LPN (Staff E) to start immediately and to call 911 and hung up. Wellness Director (Staff D) stated 911 was called and the paramedics showed up. She stated RCA (Staff A) and RCA (Staff B) stayed in the room until the paramedics arrived. Wellness Director (Staff D) restated was not initiated on Resident #1 who did not have a on file, stating Resident #1 was a Full Code. An inquiry was made to the Administrator and Wellness Director (Staff D) what Full Code meant to which they replied they should do . They further confirmed Resident #1 was not on Hospice care and was not performed on Resident #1. On at 10:41 AM, in an additional interview conducted with the Administrator and Wellness Director (Staff D) they stated it is the	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 030	Continued From page 10 facility's policy that if a resident is found unresponsive, staff should begin immediately unless the resident has a , and that staff is to do so until the paramedics arrive and take over. They confirmed that was not performed on Resident #1. On at 10:25 AM, an interview was conducted with Medication Technician (MT) (Staff H) who stated it is her understanding of the facility policy to always do regardless of until 911 responders arrive. She stated there is a logbook with a copy of a for 1 resident kept in the medication room. On at 11:04 AM, an interview was conducted with MT (Staff F) who stated she was not aware of any policy and never received any training. She stated she would use her portable radio to call for help. She stated she does not know if she should do if needed or call 911 and wait for them to do it. She further stated she is not aware which residents have . On at 11:20 AM, an interview was conducted with RCA (Staff I) regarding the facility's policy, who works in the Memory Care Unit. Staff I stated she would call the Assisted Living nurse and wait at the Memory Care door to let them in. She further stated she would call 911 and the nurse would do until 911 responds. In an interview conducted with RCA (Staff B) on at 1:28 PM, she stated she had just started her shift and was doing her rounds of checking the residents. She stated when she went into Resident #1's room she noticed she was not breathing. She stated she checked the	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 030	Continued From page 11 resident's , and had RCA (Staff A) call the nurse. She stated LPN (Staff E) came into the resident's room for a little bit, and then she left. She stated she did not know if was performed on the resident. She further stated you have to perform on a resident unless they have a . She also stated that she was not sure if the was used to try to the resident. Resident #1 did not have a on file, was Full Code status and no was performed by RCA (Staff B) when the resident was found to be unresponsive and not breathing. In an interview conducted with RCA (Staff A) on at 1:57 PM, she stated while doing her rounds at 7:10 AM she observed Resident #1 in bed. She stated that at 7:30 AM, she brought Resident #1's breakfast, and that Resident #1 took a bite of the food and threw up. She stated she informed LPN (Staff E) of the incident but did not know if LPN (Staff E) checked on the resident. She stated at 10:00 AM, LPN (Staff E) instructed her to give the resident ginger ale. RCA (Staff A) stated she gave the resident ginger ale, which she is said to have held down. RCA (Staff A) further stated in the interview, that at approximately 12:30 PM she took lunch to Resident #1 who took one bite of the turkey sandwich and started throwing up again. RCA (Staff A) stated she informed LPN (Staff E) that Resident #1 the lunch, and LPN (Staff E) came up to check on the resident. She stated that at 2:00 PM she checked on Resident #1, cleaned her up and changed her clothing. She further stated while conducting her change of shift rounds at 2:57 PM, she informed RCA (Staff B) of the resident's condition, and she and RCA (Staff B) went into Resident #1's room and observed her in bed. RCA (Staff A) stated she called Resident #1's name and got no response. She	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 030	Continued From page 12	A 030		

stated she patted Resident #1 on her , got no response and called RCA (Staff J), who came to the room but did not touch the resident. She stated she did not know if was performed on Resident #1. She restated she touched her , did not check her breath, and no one checked her . She further stated she does not know if the device was used on Resident #1. Resident #1 did not have a on file, was Full Code and no was performed by RCA (Staff A) or any facility staff when the resident was found to be unresponsive and not breathing.

In an interview conducted with LPN (Staff E) on at 3:34 PM, she stated she was called to Resident #1's room around 3:10 PM on . She stated the resident was not responding so she went downstairs to call Wellness Director (Staff D), who was not at the facility. She stated Wellness Director (Staff D) instructed her to perform , but she did not do it. No explanation was provided for her inactions. She stated LPN (Staff C) checked the resident's , and observed her not responsive, and that she did not check the resident. She also stated she does not know what the facility's policy is but knows where to go and read it. She further stated in the interview that she has not seen an machine in the facility and is not sure if it was used on Resident #1. Resident #1 did not have a on file, was Full Code status and no was performed by LPN (Staff E) or any facility staff when the resident was found to be unresponsive and not breathing.

Review of Resident's #1's record and documents contained no documentation that was performed on Resident #1, when she was discovered unresponsive and not breathing. In addition, interviews with facility staff also revealed

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
	AL11965569	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOCA RATON	9591 YAMATO ROAD BOCA RATON, FL 33434

(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
A 030	Continued From page 13 facility staff failed to initiate and perform or utilize the onsite device on Resident #1 who was a Full Code status, even after being directed to do so by Wellness Director (Staff D) via telephone to immediately perform and call 911. On at 3:20 PM, arrived at the facility and went to Resident #1's room. Resident #1 was pronounced at that time by personnel. Class I	A 030		