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
	AL11964916	A. BUILDING: _____ B. WING _____	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEST BOYNTON BEACH	8220 JOG ROAD BOYNTON BEACH, FL 33437

(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
ZZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	ZZ830		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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ZZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	ZZ830		

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ZZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit their Comprehensive Emergency Management Plan (CEMP) annually to the local Emergency Management Agency in a timely manner. The findings included: A review of documentation provided by Administrator revealed a letter from the local emergency management Agency stating the facility's comprehensive emergency management plan (CEMP) dated . . . was approved until . A review of the local emergency management's CEMP portal revealed the facility's CEMP had been in rejection status since . There was no documentation of any subsequent resubmissions on the portal or in the facility documentation. During an interview with the Administrator on at 10:30 AM, the Administrator stated that she submitted CEMP on . . , however it was rejected because she was missing the fire plan. The Administrator further stated that she had not resubmitted the report within 30 days of her last rejection due to not having a finalized fire plan. She was notified that she was not in compliance due to the facility's failure to resubmit the CEMP timely. The Administrator acknowledged the findings.	ZZ830		

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ZZ830	Continued From page 3 Class III	ZZ830		

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A 000	Initial Comments An unannounced Relicensure, Complaint (#2025007797, #2024002135, and #2024010039), Limited nursing Services (LNS) and Generator Monitoring survey was conducted on through at Brookdale West Boynton Beach. Deficiencies related to the Relicensure and Complaint (#2024010039) survey were identified.	A 000		
A 028	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to offer supervision of or assistance with activities of daily living as needed by 2 of 3 sampled residents (Resident #13 -14). This was evidenced by the facility's failure to provide care and grooming for the identified residents. The findings included: A review of the facility's documentation provided revealed a policy titled, " Activities of Daily Living (ADL) Care Documentation Policy" (effective , revised). The policy stated the following: Policy Overiew It is the expectation that the activities of daily	A 028		

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A 028	Continued From page 1	A 028		

living (ADL) care outlined on the resident's service plan will be delivered to the resident as schedule. Completion of ADL care needs is documented electronically using the companion device in PointClickCare (PCC). ADL care outlined on the resident's service plan that has not been given should be reported to the manager on duty, oncoming shift and documented in the electronic resident record.

Policy Detail
A. ADL Care- Assistance with Activities of Daily Living

1) ADL care that is not performed whether because of resident declination or other circumstance should be documented in the resident's record along with the reason ADL Care was not performed by the nurse/designee.

A) During a tour of the facility's memory care unit on at 10:19 AM Resident #13 was observed seated in a wheelchair in the hallway with her adult briefs exposed and feces smeared on the blanket beneath her. Feces stains were also present on the floor. Resident #13 had brusing and a welt on her , crusted uncombed hair, and overgrown, brown stained . She was left unattended in the soiled wheelchair by her room (247) while the care staff assisted other residents at the opposite end of the hall. At 10:23 AM, Staff Z (Direct Care Staff) was observed ambulating other residents past Resident #13 while she remained sitting in her own feces. Staff Z then wheeled the chair closer to Resident #13's room door so she would not the hallway. Resident #13 repeatedly called for help while the staff continued to pass her in the hallway. At 10:33 AM, Staff AB wheeled the

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A 028	Continued From page 2 resident into her room to perform ADL care, while Staff B (Registered Nurse) advised housekeeping and Staff Z to clean the hallway. At 10:39AM, Staff AB (Direct Care Staff) stated the brusing and welt on Resident #13's were from a that occured a week or two prior. A review of Resident # 13's file revealed an admission date of , along with a Resident Health Assessment form (AHCA form 1823) dated . The documents showed that Resident #13 had diagnoses of , , , and Polyneuropathy. She was receiving Physical and , , , as needed and required assistance with all activities of daily living except eating, which she completed independently. The facility's service plan indicated that Resident #13 was to receive assistance with grooming. During an interview conducted with Staff B on 3:28 PM, she stated that the care staff frequently call out and the unit was often short-staffed. She explained that management was aware and she tried her best to ensure all the residents received the care they needed. She also stated that she performed the majority of care in the unit and the other staff required ongoing retraining and verbal prompting. During an interview with the Administrator and the Health and Wellness Coordinator (Staff H) on at 4:21 PM, both acknowledged that staff in the memory care unit were not consistently performing ADLs for Resident #13 as outlined in her service plan and confirmed the findings. B) During a tour of the facility's memory care unit on at 10:21AM, Resident#14 was	A 028		

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A 028	Continued From page 3 observed ambulating in his weelchair up and down the hallway near Resident #13's room while Resident #13 remained waiting in her wheelchair. Further observation revealed that Resident #14 had an open, bloody on his . The Agency intervened and notified Staff B that Resident #14 was . Resident #14 then touch the and smeared on his and clothing. Upon close examination, Resident #14 had overgrown that were scratched and bloodied, accompanied by a strong -like odor coming from his wheelchair. Staff B confirmed the was self-inflicted due to the resident's tendency to scratch himself and stated she would clean it and apply a bandage immediately. When the Agency asked Staff B when she trimmed his nails, she responded that she would complete it right away. During a tour of the facility's memory care unit on at 8:11AM, Resident #14 was observed seated at the breakfast table wearing double-long sleeve shirts to prevent scratching; however, his nails were still uncut and dirty. A review of Resident #14's file revealed an admission dated of , along with a Resident Health Assessment form (AHCA form 1823) dated . The documents showed that Resident #14 had diagnoses of , , and Retention. Resident #14 had physical limitations that required assistance with ADLs and was receiving Home Health, , and , services. He required assistance with all activities of daily living except eating, which he completed independently. He did not have documentation of a facility service plan on file. During an interview conducted with the	A 028		

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A 028	Continued From page 4 Administrator and the Health and Wellness Coordinator on at 4:10 PM, they were notified that the care staff in the Memory Care Unit were not performing ADLs as needed for Resident #14. Both acknowledged that staff in the memory care unit were not consistently performing ADLs for Resident #14 and confirmed the findings. Class III	A 028		
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	A 030		

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A 030	Continued From page 5 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 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	A 030		

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A 030	Continued From page 6 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 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 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.	A 030		

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A 030	Continued From page 7 (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 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	A 030		

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A 030	Continued From page 8 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 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	A 030		

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A 030	Continued From page 9 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 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 observation, interview, and record review, the facility failed to ensure residents were provided care and supervised by qualified and appropriately credentialed staff. The facility did not verify 1 out of 4 sampled nursing staff's	A 030		

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credentials (Staff B); allowed Staff B to provide nursing care without a license, and failed to identify multiple discrepancies in her background screening records. It was determined that Staff B performed medication administration and clinical tasks despite having no valid nursing license. These failures placed the entire resident census (117 out of 117 residents) at risk, jeopardizing their health, safety, and well-being and violating their right to a safe, decent living environment.

The findings include:

I) During an observation on at 9:55AM, Staff B assisted Resident #12 with medications without performing hygiene. Staff B did not announce all medications and gave inconsistent statements about her credentials, first reporting she was a MedTech, then stating she was "actually a nurse", and later stating she was an RN.
From to the following concerns were identified with Staff B's medication passes:
a) Persistent lack of hygiene
b) Failure to follow medication orders as prescribed
c) Overdosing medications
d) Crushing medications that should not be crushed

These unsafe practices demonstrated the risk posed to residents and their general welfare.

II) A focused review of Staff B's license on revealed an RN license that showed [Staff B's name] with an issue date of and an expiration date of . Staff B was identified in facility records and through staff interviews as a "Registered Nurse," and she

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stated to the Agency that she was an RN. However, additional review of personnel records revealed Staff B was not a licensed Registered Nurse.

A review of Staff B's results in the Agency's Background Screening Clearinghouse on revealed that the only license associated with Staff B was her own expired CNA license. There was no nursing license affiliated with Staff B in the Florida Department of Health's licensing database (MQA). A name-based search in the Clearinghouse, which communicates directly with MQA, identified a Registered Nursing licensing belonging to Person A, who had a different social security number, was ten years younger, and had a different Clearinghouse person ID.

On , the Agency requested Staff B's personnel documentation/file (the entire file) . Review of the file failed to indicate a job description for an RN. The Business Office Manager reported that the file did not contain an RN job description for Staff B, despite Staff B being employed in an RN-titled position. The Business Office Manager then provided a "Nurse - RN" job description and stated that Staff B would sign it that same day, demonstrating the document had not been maintained as part of Staff B's original employment or qualification record. The Business Office Manager then provided the Agency with a " Nurse - RN" job description dated that was signed by Staff B on .

The RN job description required a "Current State RN License" and included duties restricted to licensed nursing personnel. These duties included:

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A 030	Continued From page 12 (1) "Assessment, care planning, implementation, and evaluation of nursing care." (2) "Administration of prescribed medications and . . . " (3) "Clinical documentation and observation of resident condition." (4) "Direction and supervision of Charge Nurses and CNAs." (5) "Participation in care plan meetings and QA programs." (6) "Monitoring and assessment of clinical systems for concerns and trends, reporting findings to Nursing Administration." Further review of the file yielded a physical copy of Person A's license with Staff B's employment records. During interviews on , Staff B and the Business Office Manager stated that this RN license was what Staff B brought in when she sought a promotion. The Agency determined the RN license belonged to Person A and there was no evidence Staff B had ever been licensed as an RN or LPN. III) A review of facility records, including Medication Observation Records, Adverse Incident Reports, and staff schedules, showed that Staff B: a) Documented incident reports and facility records regarding residents as a Registered Nurse b) Presented as a Registered Nurse to residents and their representatives, allowing them to contact Staff B for healthcare concerns and problem resolution c) Documented clinical tasks, including administration, without a nursing license. d) Supervised direct care staff and trained the staff regarding care and services in the Memory Care Unit.	A 030		

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A 030	Continued From page 13 On and between 8 AM and 9AM, multiple care concerns related to ADL care for the Memory Care Residents were identified. The staff on duty at the time of the survey were overseen by Staff B. Staff B was identified by other staff as the designated supervisor for the direct care staff in the Unit. However, despite Staff B's presence in the unit, multiple staff members were observed not performing assigned duties,. On at 12:35PM, the Agency notified the Administrator and the Director of Clinical Care (Staff N) of the discrepancies in Staff B's credentials. The facility's corporate office initiated an internal investigation and provided Adverse Incident Reports, background screening information, and personnel documents. A review of these records revealed the following: a) Staff B's file did not contain verified nursing credentials b) The RN license present in the staff file belonged to Person A, not Staff B c) Supervisory staff did not identify mismatched credentials presented for promotion d) Staff B was promoted and permitted to function as nursing staff in the Memory Care and Assisted Living despite lacking a valid license. During an interview on at 3:19 PM, the Health and Wellness Coordinator (Staff H) stated she believed Staff B had gone to nursing school and assumed she was an RN based on what she presented. She also stated she did not think it was abnormal for an RN to report to an LPN and saw nothing wrong with the arrangement. Additional interviews conducted on at 10:48 PM with the Health and Wellness Coordinator and Health and Wellness Director at	A 030		

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A 030	Continued From page 14 11:43AM confirmed: a) The facility relied on Staff B to oversee unlicensed staff b) Staff B routinely supervised care despite lacking credentials c) The facility did not routinely audit staff credentials or competency These admissions by supervisory staff demonstrated that the failure to ensure qualified personnel was systemic and not an occurrence. The facility failed to protect residents' rights to receive care from qualified, licensed personnel. The facility's lack of credential verification, acceptance of an RN license belonging to another individual, and reliance on Staff B to supervise care created a pattern of systemic noncompliance. This failure placed all residents at for harm and jeopardized their safety, health and well-being. Class II	A 030		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication	A 052		

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A 052	Continued From page 15 name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or , medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents	A 052		

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A 052	Continued From page 16 used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident	A 052		

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to take medications as prescribed.
(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.
(f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S.
(g) As used in Section 429.256(4)(h), F.S., the

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A 052	Continued From page 18 terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that licensed and unlicensed staff (Staff B-C, H, and F) followed required medication and hygiene procedures. In the Memory Care and Assisted Living, staff did not follow the proper steps when assisting with self-administration of medication for 3 of 9 sampled residents (Residents #5, #12, and #22). Additionally, staff did not follow hygiene during medication administration for 4 out of 9 sampled residents (Residents # and #17-18), staff did not hold appropriate credentials when administering crushed medications to 1 of 9 sampled residents (Resident #6), and staff did not review the Medication Administration Record (MAR) before administering medications for 2 of 9 sampled residents (Residents #). This failure created a risk for medication errors and resident harm. The findings included: A) 1) During an observation of a medication pass in the assisted living on between 9:00 AM and 10:00 AM, Staff C (Medication Technician) was observed assisting with the self-administration of medication for Resident#5.	A 052		

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A 052	Continued From page 19 Resident #5 was assisted with self-administration with the following medications: a) 20 mg tablet, give one tablet by two times a day for b) 40 mg tablet, give one tablet by one time a day for c) , 500 mg tablet, give one tablet by daily for d) 20 mg tablet, give one tablet by once daily for e) ER tablet extended release 20 Milliequivalents (MEQ), give two tablets by one time a day for low Do not chew or crush, swallow whole. f) , 10 mg tablet, give one tablet by once daily for A review of an informational website, www.webmd.com revealed, was meant to be swallowed whole. Chewing, crushing, breaking, or sucking the tablet could irritate the or and could cause the medication to release too quickly. Further observation of the medication pass revealed that Staff C placed all of Resident #5's medications in a small plastic bag and then inserted the bag into a pill-crushing device, where she crushed all the medications at once. During an interview on at 9:45 AM, the Agency asked Staff C whether Resident #5 had a physician order allowing medications to be crushed, and she stated she did not know. The Agency then asked Staff C to confirm if the MOR (electronic MOR) documented that the medications administered during the pass were to be crushed, she stated no. Staff C then stated she crushed all the medications because Resident #5 did not like to swallow pills. Staff C	A 052		

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A 052	Continued From page 20 also confirmed that she had not reported these findings to the Health and Wellness Director (Staff L). 2) A review of an informational website, www.nurse.org, revealed that a Registered Nurse (RN) was a medically trained professional who cared for patients. A registered nurse was a licensed professional who performed -on care and carried out duties such as administering and monitoring medications, reviewing medical records, and maintaining documentation. During an observation of a medication pass in the memory care unit on between 7:45 AM and 8:50 AM, Staff B (Registered Nurse) was observed assisting with the self-administration of medication for Resident#12. Resident #12 was assisted with self-administration of the following medications: a) , 2.5 mg tablet, give one tablet by one time a day for , , . b) 10 mg tablet, give one tablet by one time a day for , , symptoms. c) , , mg tablet, give one tablet by one time a day for , ( ) prophylaxis. d) 324mg tablet, give one tablet by one time a day for . e) 1mg tablet, give two tablets by one time a day for replacement. f) , 5 mg tablet, take one half tablet by twice a day for type 2 (as documented on the medicine bottle). Photo evidence obtained. g) , 25 mg tablet, give one tablet by one time a day for , , . h) 100 mg capsule, give one capsule by two times a day for	A 052		

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A 052	Continued From page 21 i) Linezolid 600 mg tablet, give one tablet by two times a day for . j) 500 mg tablet, give one tablet by two times a day for . k) 10 mg tablet, give one tablet by two times a day related to unspecified disturbance. l) 500 mg tablet, give one tablet by two times a day for . Further observation of the medication revealed that Staff B placed a 5 mg tablet into the medication cup without using a pill-cutting device to split the tablet as required for Resident #12. During an interview on at 8:10 AM, the Agency asked Staff B why she did not cut the tablet in half as directed on the medication label. Staff B stated she was not aware of the instruction written on the label. During an interview on at 8:20 AM Staff H (Nurse/Health Wellness Coordinator) the Agency requested that she provide a copy of the electronic Medication Record Observation (MOR) for Resident #12 for to current. A record review of the MOR dated 11/1/2025 - revealed that the directions for 5 mg stated the order was for 1 tablet by one time a day. Therefore, the MOR did not match the directions on the medication label. During an interview on at 9:35 AM with Staff H, she was notified that Staff B failed to read the label and MOR during the medication pass for Resident #12. Staff B did not acknowledge the discrepancy between the MOR and the label direction for 5 mg.	A 052		

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A 052	Continued From page 22 3) During an observation of a medication pass in the memory care unit on between 7:45 AM and 8:30 AM , the Health and Wellness Coordinator (Nurse, Staff H) was observed assisting with the self-administration of medication for Resident #22. Resident #22 was assisted with self-administration with the following medication: a) Clear and Natural Powder, give one scoop by one time a day, mix in 8 ounces (oz) of liquid. Further observation of the medication pass revealed that the medication bottle had a paper copy prescription attached with a rubber . Staff H was observed preparing the Clear and Natural Powder by pouring water into a 5-ounce cup and using a spoon to scoop the powder in the cup. During an interview on at 7:58 AM, the Agency asked Staff H if she was aware that she used a 5-ounce cup instead of the required 8-ounce cup. Staff H stated she thought the cup was 8 ounces. Additionally, the Agency asked Staff H why she used a spoon instead of the required scoop, and she stated she did not have a scoop. At the time, Staff H acknowledged that she did not follow the direction of use written on the prescription attached to the bottle. B) 1. During a medication administration observation conducted on at 8:32 AM with Staff F, Licensed Practical Nurse (LPN), who stated she has worked at the facility for 3 months. She	A 052		

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A 052	Continued From page 23 stated Resident #6 was scheduled for ˘ (BG) check and one medication; however, she did not review the MAR on the computer. Then, without performing hygiene, Staff F dispensed the following medication: , ˘ oral tablet 0.5 mg to give 1 tablet by three times daily for . She then gathered the following supplies ˘ , lancets, and test strips and stated that the ˘ is specific to this resident and not used for any other. She knocked and entered Resident #6's room. Staff F don on clean gloves, again no hygiene was performed, and checked Resident #6's ˘ then administered , ˘ 0.5 mg. She removed the gloves and without performing hygiene left the resident's room with the ˘ . She then stored the ˘ in the medication cart and stated she was going to the next resident and at this time used the sanitizer located on the cart. 2. On 8:49 AM, an observation for medication administration was conducted with Staff F for Resident #5 for the following medication: oral tablet 100mg to give 1 tablet by daily for , (high ,), hold for , ( ) less than 120 or rate (. Staff F dispensed the above medication and grabbed the ( ) machine. Without performing hygiene, Staff F entered Resident #5's room and don on clean gloves, attached the cuff and machine to the resident. She then stated that Resident #5's was and the , removed the cuff, handed the , , medication and Resident #5 took the medication. Staff F removed her gloves and exited the room, again did not perform hygiene. She returned	A 052		

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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) COMPLETE DATE
A 052	Continued From page 24 to the medication cart and was asked by the surveyor if the , , medication had any parameters ordered. Staff F never turned on her computer to check orders in Point Click Care (PCC), then she was observed looking at the medication bubbled pack and could not locate where the parameters were on the label. Then the surveyor pointed to the handwritten parameters on the top right corner of the medication bubbled pack. During an interview with Staff F, who stated that Resident #5's , but since the resident appeared okay; however, she was unable to explain why she administered the , , medication even though the , was out of the parameters. 3. On at 12:26 PM, a medication administration observation was conducted with Staff B, Registered Nurse (RN) for Resident #16. The resident was in the dining room in the Memory Care Unit She had PCC open and was able to review the orders for Resident #16 for , oral tablet 0.5 mg to give 1 tablet three times daily. Staff B pulled the , 0.5 mg bubble pack located in the medication cart and a medication cup. Without performing hygiene, Staff B approached Resident #16, punched the medication into the cup and gave it to Resident #16. Staff B returned to the computer, typed in as medication administered, however, no hygiene was conducted. 4. On at 12:31 PM a medication administration observation was conducted with Staff B for Resident #17. Without performing hygiene, she was observed dispensing the following medications into a medication cup: C oral tablet 500 mg to give 1 tablet daily	A 052		

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	AL11964916	A. BUILDING: _____ B. WING _____	11/19/2025

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BROOKDALE WEST BOYNTON BEACH	8220 JOG ROAD BOYNTON BEACH, FL 33437

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A 052	Continued From page 25 for supplement and oral tablet Delayed Release 324 mg to give 1 tablet daily for . Staff B stated that the resident has an order to crush all medications, then she crushed the medications together. She then poured the crushed medications into a cup and added pudding to the cup. She then used sanitizer and went to the resident, who was sitting at one of the dining tables waiting for lunch. She then fed the medications to the resident. During an interview conducted on at 8:02 AM with Staff B, who stated she has worked at the facility for 24 years and she is an LPN. She stated she usually works the 3:00 PM to 11:00 PM shift; however today she switched with someone and is working the 7:00 AM to 3:00 PM shift. She acknowledged that she should use sanitizer more often. Class III	A 052		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container.	A 056		

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A 056	Continued From page 26 (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.	A 056		

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A 056	Continued From page 27 (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure documentation of medication administration was recorded in a timely manner (Resident #6 and #5) and failed to ensure that an unlicensed staff member had the credentials to crush medications and administer those medications for 1 of 9 residents reviewed for medication administration	A 056		

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A 056	Continued From page 28 (Resident #17). The findings included: Review of the facility's policy titled, "Medication & Treatment- Medication Administration Record," last revised date , included the following: Each resident must have a Medication Administration Record (MAR) or Medication Observation Record (MOR) that becomes a permanent part of the resident's record. 4. For electronic MAR/MOR systems: a. After the medication is received and consumed by the resident, the associate will document the 'Administered' chart code that reflects that the medication was taken. Review of the https://hellopharmacist.com/do-not-crush-list website dated , included the following: Although crushing pills can make taking pills easier, and may even be necessary for some (e.g., those with a), it is important to be mindful of which solid oral medications should not be crushed before consumption as it may alter their intended effects due to their specific formulation. Crushing delayed-release medications can disrupt the protective mechanism designed to shield the drug from acids or prevent irritation. 1. During a medication administration observation conducted on at 8:32 AM with Staff F, Licensed Practical Nurse (LPN), who stated she has worked at the facility for 3 months. She stated Resident #6 was scheduled for (BG) check and one medication: oral tablet 0.5 mg to give 1 tablet by three times daily for . However,	A 056		

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A 056	Continued From page 29 Staff F dispensed the above medication without reviewing the MAR. After the medication was administered and BG reading was obtained, Staff F returned to the medication cart and without documenting the BG reading or the administration of , 0.5 mg, she started moving the medication cart to the next resident. At this time, an interview was conducted with Staff F and when asked where she documents the BG reading and medication administration, she stated she writes them (BG readings) on her note , , then documents them later in Point Click Care (PCC). Then, observed the nurse take her note , and wrote down the BG reading. 2. On 8:49 AM, an observation for medication administration was conducted with Staff F for Resident #5 for the following medication: oral tablet 100mg to give 1 tablet by daily for , {high , }, hold for , { } less than 120 or rate (, . Staff F dispensed the above medication and grabbed the { } machine. She then stated that Resident #5's was and the , removed the cuff, handed the , , medication and Resident #5 took the medication. Staff F returned to the medication cart and was asked by the surveyor if the , , medication had any parameters ordered. Staff F never turned on her computer to check for the order in PCC, then she was observed looking at the medication bubbled pack and could not locate where the parameters were on the label. Then the surveyor pointed to the handwritten parameters on the top right corner of the medication bubbled pack. During an interview with Staff F, LPN, who stated	A 056		

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A 056	Continued From page 30 that Resident #5's , but since the resident appeared okay therefore, she administered the medication; however, she was unable to explain why she administered the medication even though the was out of parameters. 3. During an interview conducted on at 8:02 AM with Staff B (Registered Nurse), who stated she has worked at the facility for 24 years and acknowledged that she was an LPN. She stated she usually works the 3:00 PM to 11:00 PM shift, however today she switched with someone and is working the 7:00 AM to 3:00 PM shift. During a medication administration observation conducted on at 12:31 PM for Resident #17 with Staff B, who then stated she was a Registered Nurse (RN), she was observed dispensing the following medications into a medication cup: C oral tablet 500 mg to give 1 tablet daily for supplement and oral tablet Delayed Release 324 mg to give 1 tablet daily for . Staff B stated that the resident has an order to crush all medications, then she crushed the medications together. She then poured the crushed medications into a cup and added pudding to the cup. She then used sanitizer and went to the resident, who was sitting at one of the dining tables waiting for lunch. She then fed the medications to the resident. Staff B record review revealed she had a license as an RN; however, the name was slightly different. Further review of the records acknowledged discrepancies in Staff B credentials and identifying the possibility of Staff B being an unlicensed person. In addition, she	A 056		

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A 056	Continued From page 31 crushed and administered oral tablet Delayed Release 324 mg to Resident #17, which should not be crushed due to diminishing the delay release of the medication over a period to provide proper medication effect and prevent irritation. Class III	A 056		
A 077	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.	A 077		

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A 077	Continued From page 32 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not	A 077		

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A 077	Continued From page 33 to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator	A 077		

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A 077	Continued From page 34 form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility's Administrator failed to act when reasonable cause existed to question 1 out of 4 sampled nurses' eligibility for employment (Staff B). The facility failed to initiate disqualification procedures until the Agency intervened and identified fraudulent nursing credentials. The Administrator failed to ensure that appropriate screening of all credentials were completed by the Human Resource Manager(Representative) prior to , , of a Direct Care Staff and Licensed Staff (specifically, Staff B). The findings included: On at 9:55 AM, the Agency observed Staff B conducting a medication pass for Resident #12. During this observation, Staff B failed to perform hygiene and did not identify or announce the medications being administered. At 10:10 AM, when questioned about her credentials, Staff B stated she was "actually a nurse," later indicating she was an RN. During an interview on at 3:25 PM, Staff B stated she assisted with medications because she was a Registered Nurse. On at 8:02 AM, Staff B stated she had worked for the facility for 24 years and confirmed she was an LPN. Later that morning, at 10:56	A 077		

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A 077	Continued From page 35 AM, Staff B was unable to recall when or where she completed nursing school, when she became licensed, whether she completed an RN or LPN program, or which state issued her license. She reported she could not locate her credentials and exited the interview without providing documentation. A focused review of Staff B's license on revealed an RN license that showed [Staff B's name] with an issue date of and an expiration date of . A Background Screening Clearinghouse search conducted the same day showed that Staff B had no RN or LPN license under her identifiers, and her only listed credential was an expired CNA certificate dated . A secondary verification on Background Screening Clearinghouse confirmed that the RN license contained in the file belonged to another individual, identified as Person A, not Staff B. On , the Agency requested Staff B's entire file from the Business Office Manager (HR Representative) due to the identified discrepancies. During a record review of Staff B's file with the Administrator and the Business Office Manager, the Agency identified that the file did not contain a required RN job description, despite Staff B being titled, scheduled, and functioning as a Registered Nurse. The Business Office Manager acknowledged that the job description was not maintained in Staff B's file and stated she would have Staff B sign one that same day ( ). The Business Office Manager then provided the Agency with a generic "Nurse - RN" job description dated . The Business Office Manager then provided the Agency with a " Nurse - RN" job description dated that was signed by Staff B on .	A 077		

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A 077	Continued From page 36 The job description required a "Current State RN License," and listed essential duties that could only be performed by a licensed Registered Nurse. These duties included: (1) "Implements and coordinates the delivery of care in collaboration with physician and resource personnel." (2) "Utilizes the nursing process (assessment, planning, implementation, and evaluation) in applying nursing knowledge." (3) "Sets up and administers prescribed medications and treatments including ' ' ." (4) "Provides functional direction and assistance to Charge Nurses and CNAs." (5) "Directs resident care to include making rounds on a timely basis to ensure continuity of care." (6) "Documents all pertinent information regarding nursing care, care plans, observation of the resident's condition, and response to treatment." During an interview with the Business Office Manager on at 11:38 AM, she stated credential checks were performed through Certify, which does not verify active state licensure, and reported she had never directly verified an RN license with the licensing board. On at approximately 12:20PM the Director of Clinical Services (Staff N) and the Administrator reviewed Staff B's file with the Agency. At this time, the Director of Clinical Services identified the same discrepancies noted by the Agency. She asked the Agency to bring Staff B in for a follow-up interview to clarify the concerns. The Administrator called for Staff B to meet with the Agency and the Director of Clinical Services but there was no response. After several	A 077		

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A 077	Continued From page 37	A 077		

minutes, Staff B never arrived and the Director of Clinical Services went to retrieve her from the Memory Care Unit where she was still performing her assigned job duties.

On at approximately 1:20 PM, the Director of Clinical Services arrived in Memory Care to retrieve Staff B from her work area. When the Director of Clinical Services began walking towards Staff B from the elevator (on the second floor), Staff B fainted while working at 1:28PM. Staff B was evaluated by the emergency services. During an interview with emergency services at approximately 1:50PM, they stated that Staff B was nervous and they were going to transport her to the hospital for additional observation. The sheriff's department responded, and the Agency provided all relevant investigative documentation.

During an interview conducted with the Director of Clinical Services on at 2:20 PM, she confirmed that when she made , contact with Staff B upon entering Memory Care, Staff B fainted at the sight of her.

Interviews conducted on at 10:48 AM and 11:43 AM with the Health and Wellness Coordinator (Staff H) and Health and Wellness Director (Staff L) revealed that the facility relied on Staff B to train unlicensed staff and did not routinely audit staff credentials. The Coordinator stated she did not believe it was abnormal for an RN to report to an LPN and saw nothing wrong with the arrangement.

On at 11:12 AM, the Director of Clinical Care stated Staff B had been suspended pending investigation. She further reported that the sheriff's department attempted to interview

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	AL11964916	A. BUILDING: _____ B. WING _____	11/19/2025

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BROOKDALE WEST BOYNTON BEACH	8220 JOG ROAD BOYNTON BEACH, FL 33437

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A 077	Continued From page 38 Staff B in the hospital, but she was , , and the deputy advised there was probable cause to pursue criminal charges for licensure fraud. The Director also confirmed that the facility had filed a complaint with the Florida Department of Health, MQA. During an interview with the Administrator and Corporate Staff on at 6:25 PM, they were notified that for approximately three years, the facility failed to review, validate, or reconcile Staff B's credentials and did not implement its authority to remove or investigate her despite multiple indicators of misrepresentation. This allowed Staff B to impersonate a nurse and perform licensed nursing functions without qualification until Agency intervention. Class II	A 077		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no	A 152		

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A 152	Continued From page 39 less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe living environment free of hazards with maintained appurtenances in good working order. The findings include: During a tour of the facility conducted from to , the following concerns were identified: Memory Care: 1.) On at 10:19 AM, feces was present on the floor dripping from Resident #13's wheelchair in the hallway next to .	A 152		

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A 152	Continued From page 40 2.) On at 3:58 PM, had a fecal-like stain present around the base of the toilet and surrounding area. 3.) On at 8:25 AM, dried food debris and brown stains were present on the walls, chair rails, electrical sockets and baseboards throughout the entire dining room. 4.) On at 12:46 PM, peeling cabinet paint present in the kitchen area while food items were exposed on the countertops and food warming area. Assisted Living Facility: 1.) On /25 at 12:45 PM, sticky flooring present throughout the entirety of Dining # and the tables were covered in scuff marks. 2.) On at 2:04 PM, drywall ceiling in Dining # had a patched over hole with moisture accumulation present and there was a strong mildew-like odor coming from the carpeting in the room. 3.) On at 2.06 PM, drywall ceiling in Dining # had moisture bubbles in the paint and black mold-like patches throughout the entire room. Additionally, the tables in Dining # were covered in various scuff marks. Observations of Dining # # on /25 at 12:35 PM and at 2:06 PM yielded a total of approximately 68 chairs that were stained with food-like matter and had chipping paint and chipping wood. The poorly maintained condition of the chairs posed safety concerns for the residents.	A 152		

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A 152	Continued From page 41 During an interview on at 10:28 AM with the Administrator, she stated that she was aware of the conditions of the dining room chairs in the dining rooms and she was waiting on estimate for the chairs' repair cost. The Agency notified her of the ongoing concerns with mold-like odors and staining throughout the facility, she acknowledged the findings. Class III	A 152		
A 163	429.49 FS Records - Resident, Penalties for Alteration (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed ensure the accuracy and integrity of documentation submitted to the Agency. The facility provided falsified AIRS reports that contained incorrect social security numbers and falsified licensing credentials for Staff B, which resulted in the Agency receiving inaccurate regulatory records. The findings included: On at 1:15 PM, the Agency notified the Administrator and the Director of Clinical Care (Staff N) of discrepancies identified in Staff B's	A 163		

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A 163	Continued From page 42 credentials. The facility's corporate office initiated an internal review and provided the Agency with AIRS Adverse Incident Reports, background screening information, and personnel documentation for comparison. A record review revealed multiple inconsistencies involving Staff B's social security number and licensure information across several AIRS reports submitted to the Agency. An I-9 document contained Staff B's correct social security number; however, the Registered Nurse license attached in Staff B's personnel file, issued in 2017 and expiring in 2027, belonged to another individual (Person A). Further review of AIRS Adverse Incident Report Part 1.0 dated contained Staff B's correct social security number per the I-9, but an unidentified LPN license was listed as her credential. Additional AIRS reports (Part 1.1 dated and Part 2.0 dated) listed Staff B's correct social security number but showed out-of-state temporary licenses that did not belong to Staff B as the credential. An AIRS report dated contained a social security number that did not match Staff B's I-9, listed an out-of-state temporary license as the credential, and documented Staff B as the LPN on duty. An AIRS Part 2.0 report dated also contained a social security number that did not match Staff B's and again listed an out-of-state temporary license with Staff B documented as the RN on duty. A subsequent AIRS report (Part 2.1 dated) contained a social security number not affiliated with Staff B, along with an attachment of Person A's Florida nursing license, and documented Staff B as the RN on duty.	A 163		

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A 163	Continued From page 43 As these discrepancies were identified, the Administrator stated she was the individual who input all licensing credentials and social security numbers into the AIRS reports. She reported that she believed the social security numbers she used were linked to Staff B's licensing information and therefore continued to enter them across multiple submissions. During a follow-up interview on at 10:52 AM, the Administrator admitted she was solely responsible for submitting and verifying all information included in the AIRS Adverse Incident Reports. She stated she verified all information included in the report by conducting an internal review. When questioned about how she mismatched social security numbers, licenses, and personal identifiers across multiple reports, the Administrator stated she did so mistakenly while copying and pasting from previous reports. The Agency notified her that, regardless of intention, submitting incorrect identifiers and mismatched licensure constituted falsification of documentation. The Administrator acknowledged these findings. Class III	A 163		