

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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 Relicensure, Complaint (#2025009136, #2025011442 and #2025018464) and Generator Monitoring survey was conducted on _____ at Grand Villa of Boynton Beach. The facility had deficiencies related to the Relicensure at the time of survey.	A 000			
A 010	429.26() FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident,	A 010			

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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 010	Continued From page 1 additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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 010	Continued From page 2 applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a _____ may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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 010	Continued From page 3 record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A _____ ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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 010	Continued From page 4 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement an interdisciplinary care plan with hospice that identifies, coordinates, and ensures delivery of the additional care and services required for a ill resident to remain in the Assisted Living Facility, for 1 of 2 sampled residents (Resident #16). The findings include: During an interview with the Administrator on at approximately 11:00 AM, Resident #16 file and hospice notes were requested and reviewed. The following was noted: A record review of Resident #16's record revealed that the resident was admitted to the facility on . Further review of the resident's file revealed the Health Assessment (Agency for Health Care Administration Form 1823), dated , documented the following: Nursing/Treatment/ Requirements: Medication management / Hospice, /Behavioral Status: , Special Precautions: precautions. Activities of Daily Living (ADLs): showed that the Resident was Independent with ambulation, eating, and transferring, required supervision fir , self care, and toileting. The Resident needs assistance with self administration of medications. During an interview with the Administrator on at 12:30 PM, she confirmed that Resident #11 was receiving hospice services.	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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 010	Continued From page 5 When requested, she provided a binder she identified as containing hospice documentation and records of care and services provided by the facility. A record review of the binder revealed a Hospice Certificate and Plan of Care documenting a start-of-care date of _____. However, the binder contained no documentation of the specific care and services provided by the facility in accordance with the hospice plan. Further review found no interdisciplinary care plan developed jointly between hospice and the facility. Missing elements included: - o Identification of services hospice is responsible for providing - o Identification of services the facility is responsible for providing - o Documentation confirming implementation of these services by the facility - o Evidence that the plan was maintained and available in the resident's record During an interview conducted on _____ at 3:30 PM with Resident #16, she stated that she was receiving hospice services and that a nurse comes a couple days during the week. During and interview with the Administrator on _____ at 4:30 PM, she acknowledged the absence of hospice documentation and stated that hospice does not always provide their documentation. She further stated the staff know what to do, but could not provide facility documentation verifying implementation of the services required by hospice. The facility did not provide any additional information for review prior to survey exit.	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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 010	Continued From page 6 The facility failed to ensure the presence and implementation of a coordinated interdisciplinary care plan with hospice, as required for a _____, ill resident to continue residence in an ALF. The lack of required documentation prevented verification that the resident's additional care and service needs were identified, coordinated, or met. Class III	A 010			
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. (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	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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 056	Continued From page 7 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, faxed, 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. (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	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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 056	Continued From page 8 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 observation, interview, and record review, the facility failed to ensure a physician's order was in place for , and failed to follow physician order for a medication with parameters for 2 of 4 residents reviewed for medication administration (Resident #5). The findings included: On at 12:04 PM, a medication administration was conducted for Resident #5, who was observed sitting in her wheelchair and had a (a device to deliver) attached to her and to an canister. Resident #5 stated she uses continuously and was on her way to the room to attach to an tank because the canister last about 4 to 5 hours.	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435			
(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 056	Continued From page 9 Record review for Resident #5 revealed the resident was re-admitted to the facility on _____ with diagnoses that included: _____ (_____); _____. Record review of Resident #5's physician orders revealed no documentation of an order for _____. During an interview conducted on _____ at 3:58 PM with the Resident Care Manager, (RCM), who stated she has worked at the facility for 2 years. She stated the residents who use _____ are followed by their provider or the home health agencies. The facility does not deal with the settings for _____ canisters or tanks; however, the provider will assure that the resident can manage _____, meaning the provider will assess the residents to ensure they can manage their own _____. She stated _____ requires a physician order and it's added to the resident's paper chart. RCM stated Resident #5 does use _____ but did not think it was continuous, but she does have an order for the _____. At this time, a review of Resident #5's physician orders was conducted with the RCM, which acknowledged that there was no order for _____ as of _____. Class III	A 056			
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.;	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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 152	Continued From page 10 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 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 record review, observation, and interview, the facility failed to maintain a safe and decent living environment for all residents that reside at the facility.	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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 152	Continued From page 11 The findings include: During an interview conducted on _____ at 10:00 AM, the Administrator was asked to provide the Department of Health (DOH) Group Care and public pool inspection reports for the past two years. Review of the DOH Group Care inspection report dated 2025, indicated unsatisfactory inspection results, documenting physical plant violations. 1.No hot water at handwashing sinks in residents' rooms. 2.Hot water at sinks in resident rooms exceeding temperature of 100 degrees fehenhight. 3. The facility has hazardous structural damage that needs Maintenance repairs; uneven flooring surfaces, displaced ceiling tiles, stained carpets in resident rooms, holes in walls, damaged base boards. 4. Strong offensive odors in hallway common areas and resident rooms. 5. Nonfunctioning lights in resident rooms on the 2nd floor and resident rooms on the 4th floor. 6.Plumbing needed leaking pipe at sink in resident room, toilet not flushing. 7. Soiled linens on the floor in resident room, stained bed sheets on resident beds. 8. Mattress covers missing for all residents. 9. Missing proper storage in shared Resident rooms and bathrooms, that personal toiletries are unsanitary storage. Further review of the DOH Group Care inspection report dated 2025 reveals reinspection date of _____ During an interview conducted on _____ at 3:30 PM The Administrator was asked to provide the DOH Group Care reinspection report.	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435			
(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 152	Continued From page 12 Class III	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/29/2026
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GRAND VILLA OF BOYNTON BEACH

**1935 SOUTH FEDERAL HIGHWAY
BOYNTON BEACH, FL 33435**

(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
ZZ875	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with 's or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each	ZZ875		

AHCA Form 3020-0001

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

TITLE

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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
ZZ875	Continued From page 1 employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues. (e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with _____'s or related forms of _____, in addition to the training specified in paragraphs (a) and (b), employees must receive the following training: 1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d). 2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of _____-specific training. Such training must include, but is not limited to, understanding _____ and related forms of _____, the stages of _____'s _____, communication strategies, medical information,	ZZ875			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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	
ZZ875	Continued From page 2 and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning. For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or on-experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning . chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider.	ZZ875			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435		
(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	
ZZ875	Continued From page 3 (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, _____, or referred to provide services before _____, must complete the training required in this section before _____. Proof of completion of equivalent training completed before _____ shall substitute for the training required in subsection (4). Each person employed, _____, or referred to provide services on or after _____, may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility providing memory care services failed to ensure care staff completed the required _____'s _____ or related _____ (ADRD) training and video training for 2 of 4 sampled staff (Staff B & Staff K). The findings included: Upon review of the sampled staff records, it was determined that: 1) Staff B's job title was Resident Care Manager and hire date was _____. No proof of ADRD	ZZ875			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932640	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER GRAND VILLA OF BOYNTON BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435			
(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
ZZ875	Continued From page 4 training was included in the file. No proof of completion of the one-hour video training through the Department of Elder Affairs was included in the file. 2) Staff K's job title was Resident Care Assistant and hire date was No proof of completion of the one-hour video training through the Department of Elder Affairs was included in the file. On at approximately 2:40 pm missing training documents were requested from Staff D (Business Office Administrator). No additional documentation was provided. Class III	ZZ875			