STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105089	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl at Fort Lauderdale Rehabilitation and Nursin	1701 NE 26th St Fort Lauderdale, FL 33305

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to treat residents in a dignified manner for 5 of 5 sampled residents observed during dining observations, Resident #48, Resident #38, Resident #311, Resident #115, and Resident #67, as evidenced by calling residents 'feeders' and staff standing to feed residents. The findings included: Review of the facility's policy, titled, Dignity, dated 11/14/24, revealed the following, in part: The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. Staff always speak respectfully to residents, and not labeling or referring to the residents by his or her room number, diagnoses, or care needs. 1. In an observation conducted on 12/10/24 at 8:25 AM, Staff A, Registered Nurse, was noted on the 100's Hallway, passing the breakfast trays to staff. He was observed taking a breakfast tray and giving it to a staff member and said she is a feeder as he was passing the breakfast tray to the staff member. 2. In an observation conducted on 12/10/24 at 8:28 AM, Staff B, Certified Nursing Assistant (CNA), was noted sitting near Resident #32, assisting her with the breakfast meal. Resident #32's roommate (Resident #48) was in bed with her breakfast tray at the bedside. At 8:37 AM, about 10 minutes later, Staff B took Resident #32's breakfast tray out of the room and placed it in the meal cart in the Hallway. At 8:49 AM, which was about 20 minutes later, Staff B came back into the room and started assisting Resident #48 with her breakfast tray. 3. Record review revealed Resident #38 was admitted to the facility on [DATE] with diagnoses of Dementia and Hypertension. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #38 was severely cognitively impaired. In an observation conducted on 12/11/24 at 8:49 AM, Staff D, CNA, was noted feeding Resident #38 while standing over his bed. Closer observation revealed a chair at the corner of the room that was empty and not in use. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Pearl at Fort Lauderdale Rehabilitation and Nursin		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 NE 26th St Fort Lauderdale, FL 33305	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. In an observation conducted on 12/11/24 at 8:45 AM, Resident #311 was in the room with her breakfast tray at the side table. During the continued observation at 9:10 AM, Staff E, CNA, was noted standing over Resident #311 and attempting to feed her some of the food on the breakfast tray. In an interview conducted on 12/12/24 at 10:10 AM with Staff F, Certified Nursing Assistant, stated that when assisting a resident during dining they need to ensure that they are sitting near the residents at an eye level. All residents need to be treated with dignity and respect. 36057 5. On 12/09/24 at 1:36 PM, during in-room dining observation at the facility's south area, revealed Resident #67 sitting in a wheelchair by the nurses station. Subsequently, an interview was conducted with Staff C, CNA, who stated Resident #67's tray was in the tray's cart because he was a 'feeder'. Review of Resident #67's MDS quarterly assessment dated [DATE] documented the resident needed supervision or touching assistance during eating. 6. On 12/09/24 at 1:35 PM, during in-room dining observation at the facility's south area, revealed Resident #115 sitting in a wheelchair by the nurses station. Subsequently, an interview was conducted with Staff C, CNA who stated Resident #115's tray was in the tray's cart because she was a 'feeder'. Review of Resident #115's MDS quarterly assessment dated [DATE] documented the resident needed set-up or clean up assistance during eating. On 12/11/24 at 2:23 PM, an interview was conducted with Staff C, CNA who was apprised of calling Resident #67 and Resident #115 'feeders' during lunch time on 12/09/24. Staff C and replied No and added she had to say 'assist' the resident.

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F 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives an accurate assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36057

Based on record review, observations and interviews, the facility failed to accurately complete the Minimum Data Set (MDS) assessments related to medications and diagnosis for 3 of 5 sampled resident reviewed for unnecessary medications, Resident #77, Resident #167, and Resident #168.

The findings included:

1. Review of Resident #77's clinical record documented an admission on 07/25/24 with no readmissions. The resident's diagnoses included Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Fall, Chronic Pain, Tobacco Use, Cognitive Communication Deficit, Major Depressive Disorder, Nicotine Dependence, Persistent Mood Disorders, Generalized Anxiety Disorder, and Unspecified Dementia.

Review of the physician order dated 08/20/24 documented, Nicotine Patch 24 Hour 7 MG (milligrams) /24 HR (hour), apply 1 patch transdermally one time a day for Smoking Cessation and remove per schedule.

Review of Resident #77's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 14 indicating the resident had no cognition impairment.

On 12/11/24 at 4:47 PM, an interview was conducted with the Consultant Pharmacist (CP) who was apprised of Resident # 77 having a physician order for Nicotine patch and she had been observed smoking on 12/10/24 late in the afternoon. The CP stated she did not know the resident was smoking and the Nicotine patch is usually done for two months. During the interview, the CP stated that the Nicotine patch was a psychotropic medication, and she had not done a Gradual Dose Reduction (GDR) as required. The CP stated Nicotine needed to be monitored and coded in the resident's record as a psychotropic medication.

On 12/12/24 at 10:39 AM, an interview was conducted with the facility's MDS Director and Staff CC, MDS Coordinator. A side-by-side review of the resident's Quarterly MDS assessment dated [DATE] was conducted. Staff CC stated the assessment was not coded for a psychotropic medication. The MDS Director stated she was aware Resident #77 had a nicotine patch, and they (staff) were aware. She added she communicated to nursing and had a psychiatry consult who said it is okay for resident to do both (nicotine patch and smoke) as it would help to get the resident to stop smoking.

2. Review of Resident #167's clinical record documented an admission on 04/01/24 and a readmission on 08/12/24. Review of Resident #167's clinical diagnoses documented on the face sheet included Schizoaffective Disorder, Bipolar Type dated 08/12/24. The face sheet did not list a diagnosis of Schizophrenia.

Review of Resident #167's quarterly MDS assessment dated [DATE], section Active Diagnoses-Psychiatric/Mood Disorder, was not coded for Bipolar Disorder or psychotic disorder and was coded for Schizophrenia.

(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 3:22 PM, a side-by-side record review and interview was conducted with the MDS Director who stated Resident # 167 was initially admitted to the facility on [DATE] and had a readmission 08/12/24. The resident's quarterly MDS assessment dated [DATE] documented a BIMS score of 15 indicating no cognition impairment. During the review, the MDS Director stated Resident #167 had a new diagnosis of Schizoaffective Bipolar type on 08/12/24. On 12/12/24 at 10:26 AM, an interview was conducted with Staff CC, MDS Coordinator, who was asked where he gets the resident's diagnoses information and replied, 'from the doctors notes and hospital records.' Staff CC was asked where he got Resident #167's diagnosis of Schizophrenia that was coded on the MDS assessment. Staff CC replied from the diagnoses list. Staff CC reviewed the resident's diagnoses list and stated that the Schizoaffective diagnosis was always there on the list. Staff CC stated, 'it was miscode, there was not a Schizophrenia diagnosis listed'. 3. Review of Resident #168's clinical record documented an initial admission on 10/09/24 with a readmission 10/29/24. The resident's diagnoses included Effusion of Left Knee, Type 2 Diabetes Mellitus, Arteriovenous Fistula- Acquired, Hypertension, Respiratory Disorders, Generalized Anxiety and Major Depression. Review of Resident #168's MDS, the five (5) days Medicare assessment dated [DATE], documented a BIMS score of 15 indicating no cognition impairment. Review of Resident #168's physician orders during the MDS review period (10/29/24 to 11/05/24) provided by the MDS Director, documented the following medications: *10/29/24, Aspirin EC (enteric coated) tablet Delayed Release 81 MG (Aspirin) give 1 tablet by mouth one time a day for antiplatelet. *10/29/24, Cefuroxime Axetil (an antibiotic) oral tablet 250 mg, give one (1) tablet by mouth two times a day for Sepsis for 7 days. *10/29/24, Doxycycline oral tablet 100 mg, give one tablet every 12 hours for Sepsis for 19 administrations. *10/29/24, Lantus Solostar subcutaneous solution Pen Injector 100 unit/ml inject 10 units subcutaneously at bedtime for Diabetes. *10/29/24, Insulin Glargine-100 UNIT/ML (millimeters) Solution pen injector, inject 10 unit subcutaneously at bedtime for Diabetes. *10/29/24, Sertraline oral tablet 100 mg, give one tablet by mouth at bedtime for Depression. Further review revealed there was not a physician order for an anticoagulant. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 11:00 AM, an interview and a side-by-side record review of Resident #168's MDS for five (5) days Medicare assessment dated [DATE] was conducted with the MDS Director. The MDS Director stated the assessment documented the resident took an antiplatelet and anticoagulant medications seven (7) days prior to the assessment completion on 11/05/24. The MDS Director was asked to check the physician orders for anticoagulant and antiplatelet during the look back period and stated she did not see an order for anticoagulant or antiplatelet. The MDS coordinator stated she would do a modification to the assessment. The MDS Director stated the assessment was miscoded for anticoagulants and the physician's order-read Aspirin for antiplatelet. The Director added it was a click on error. The Director added the resident's assessment should have been coded for hypoglycemic and antidepressant and it was not. On 12/10/24 at 3:15 PM, during an interview with the MDS Director and Staff CC, MDS Coordinator, Staff CC stated he looked up Aspirin and it is classified as an anticoagulant, antiplatelet. The MDS Director stated Resident #168 was care planned for Aspirin medication as an antiplatelet. Staff CC was asked why the assessment was coded for an anticoagulant and replied because of the Aspirin order. On 12/10/24 at 3:36 PM, a telephone interview with the MDS Director, Staff CC and the Consultant Pharmacist (CP) was conducted. The CP stated that Aspirin can be used as an antiplatelet but not as an anticoagulant. The CP was apprised that Aspirin was coded as an anticoagulant. Review of Resident #168's MDS assessment revealed the assessment was not coded for antibiotics, antidepressant and hypoglycemic administered seven (7) days prior to the assessment completion on 11/05/24. The MDS assessment was coded for anticoagulant and there was no physician order for it.

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F 0655

Level of Harm - Potential for minimal harm

Residents Affected - Some

Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50895

Based on record review and interviews, the facility failed to ensure that the baseline care plans were completed within 48 hours for 3 of 5 sampled residents, Resident #36, Resident #508 and Resident #189.

The findings included:

1. Review of the clincial record for Resident #36 revealed an admitted [DATE]. Review of the baseline care plan for Resident #36 showed the baseline care plan was created (started by one staff member) on 11/01/24 and locked (completed by all required staff members) on 11/05/24.

2. Review of the clincial record for Resident #508 revealed an admitted [DATE]. Review of the baseline care plan for Resident #508 showed the baseline care plan was created (started by one staff member) on 11/29/24 and locked (completed by all required staff members) on 12/02/24.

3. Review of the clincial record for Resident #189 revealed an admitted [DATE]. Review of the baseline care plan for Resident #189 showed the baseline care plan was created (started by one staff member) on 10/18/24 and locked (completed by all required staff members) on 10/21/24.

An interview with the Minimum Data Set (MDS) Director on 12/12/2 at 12:30 PM revealed she thought the required time frame for completion of the baseline care plan was 72 hours (not the required 48 hours). She added that she wasn't sure and she wanted to verify this with the Director Of Nurses (DON). She left the room, returned, about 5 minutes later, and said the completion time for baseline care plans per the DON was 72 hours (not 48 hours). When asked to review the baseline care plan for Resident #189, the MDS Director said that it was completed within 3 days.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews and record review, the facility failed to implement care plans to meet the medical, physical, mental and psychosocial needs for residents on psychotropic medications for 5 of 5 sampled residents reviewed for psychotropic medications, Residents #145, #73, #86, #77 and #167; and failed to implement care plans for 1 of 1 sampled resident reviewed for antibiotic therapy, Resident #198. The findings included: Review of the facility's policy, titled, Care Plans, Comprehensive Person-Centered, dated 09/25/24, included the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the service that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. Record review for Resident #145 revealed the resident was admitted to the facility on [DATE] with re admission on 10/18/24 with the following diagnoses: Fracture of Neck of Left Femur, Type 2 Diabetes Mellitus, Major Depressive Disorder, and Primary Insomnia. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #145 had a Brief Interview for Mental Status (BIMS) score of 15, indicating he was cognitively intact. Review of the physician's orders documented Resident #145 had an order dated 11/22/24 for Trazodone HCl 50 mg tablet, to give 0.5 tablet by mouth at bedtime for Depression (Give 1/2 tablet to equal 25 mg). Review of the physician's orders documented Resident #145 had no orders to monitor side effects for Trazodone 50 mg tablet. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Quarterly Care Plan dated 11/30/24 documented Resident #145 was on psychotropic medications (Trazodone) for Depression. The goals were to be free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. Interventions included the following: Administer medications as ordered. Monitor/document for side effects and effectiveness. Monitor/record/report to MD as needed side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Offer nonpharmacologic interventions such as conversation, hand massage, diversional activities, music therapy, redirection, reassurance, education on deep breathing and relaxation techniques, or assist to a quieter environment. Review of the Psychiatry assessment dated [DATE] documented Resident #145 was unstable and required medication changes as per collected information and interview. Resident #145's symptoms are occurring almost daily due to exacerbation of underlying depressive disorder and causing severe distress. The plan of action is to start Resident #145 on Trazodone 25 mg at bedtime. An interview was conducted on 12/11/24 at 10:50 AM with Staff Z, Licensed Practical Nurse (LPN) who stated she has worked at the facility for 2 months and has been Resident #145's nurse for 2 weeks. She stated a physician's order is needed to monitor side effects of psychotropic medications and then the nurses can document in the Medication Administration Record (MAR) and progress notes for any side effect observations. An interview was conducted on 12/11/24 at 11:59 AM with Staff V, Unit Manager/UM of the [NAME] Unit, who stated she has worked at the facility for 6 months. She stated in order to monitor side effects of medications, an order is required and the nurses document the side effects in the MAR and nursing progress notes. In addition, Staff V stated MDS (coordinators) can input orders for behavior and side effect monitoring for psychotropic medications. An interview was conducted on 12/11/24 at 4:31 PM with the Director of Nursing (DON). He stated the order listing report (new medication orders) is reviewed every morning by him and the unit managers, and any addition or changes to the order will be made at that time. The DON also stated physician's orders can be input by nurses, unit managers, pharmacists, and psychology staff. He stated the psychology nurse practitioner can add an order into the computer system and only be seen under the MAR and not under the orders; however, he was not aware that side effects needed to be monitored for psychotropic medications. 50370 2. Record review revealed Resident #198 was admitted on [DATE] with diagnoses that included Hyperlipidemia, Type 2 Diabetes Mellitus with Foot Ulcer, Benign Prostatic Hyperplasia, Chronic Viral Hepatitis, Atherosclerotic Heart Disease of Native Coronary Artery, and Venous Insufficiency. Review of the MDS assessment revealed a BIMS score of 13, indicating the resident was cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the physician orders dated 11/13/24 revealed to give Meropenem I GM. (gram) into venous catheter every 12 hours. Review of nursing progress notes dated 11/13/24 revealed: The resident started on 11/13/2024 with Intravenous (IV) Medications of Meropenem Intravenous Solution Reconstituted 1 GM (gram)(Meropenem), related to cellulitis until 11/28/2024. Additional review of the nursing care plan dated 11/13/24 revealed that if the IV (intravenous) is infiltrated: stop infusion and thoroughly examine the site. If the catheter appears to be lodged in the tissues, an attempt to aspirate any fluid remaining in the catheter can be made to lessen the amount of drug at the site. After removing the cannula, elevate the affected arm, notify the physician (for large infiltrations and extravasations), and apply cool compresses (warm, if [NAME] alkaloids are involved). Additional nursing care plan interventions dated 11/13/24 revealed to check IV dressing site daily. Review of Medication Administration Record (MAR) dated 11/14/24 revealed to flush left upper arm midline catheter every shift. The same MAR revealed that nurses documented their initials from 12/01/24 until 12/10/24 indicating flushings of the midline catheter on these dates were performed. Additional review of MAR with input date of 11/14/24 revealed to perform midline to left arm check every shift and code with the following: 1= no problem, 2= edema, 3= redness, 4=pain. Further review of MAR from 12/01/24 until 12/10/24 revealed that nurses put their initials but no codes were documented on all these dates, indicating the midline left arm checked was not done per order. Further review of MAR dated 11/14/24 revealed an order to change the midline IV dressing to left upper arm as needed. From 12/01/24 until 12/11/24, there were no nurses initials recorded indicating nurses did not change the dressing as needed. Further review of nursing progress notes did not show dates when IV sites dressings were changed and documented. During observation on 12/09/24 at 9:35 AM, the resident was sitting on bed with left arm IV dressing with no date and tag. The square surrounding area had a brownish coloration and the Tegaderm (transparent medical dressing) shield was loosely covering the bottom and some sides of a white gauze dressing. When asked if he is receiving medication through the IV catheter, Resident #198 replied No. During another observation and interview on 12/11/24 at 9:30 AM, Resident #198's IV dressing were loose, and the surrounding area had reddish fluid drainage on the dressing and the surrounding area that smelled like blood. Resident #198 stated IV antibiotic was discontinued a long time ago. When asked why he still has the IV catheter on left arm, he stated he did not know, and no one informed him of why IV catheter is on his left arm. When asked if the staff were checking on the catheter, he stated not recently. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During another observation on 12/11/24 at 9:35 AM, it revealed the left arm IV access had reddish drainage around the white dressing gauze, the Tegaderm shield was 90% off the white gauze dressing, and the fluid around the dressing area smelled like blood. When asked, Resident #198 stated that the dressing and the IV access were very loose. During interview with the Director of Nursing (DON) on 12/11/24 at 2:47 PM, regarding (Intravenous) site and IV antibiotic, he added that he is aware that resident's antibiotic was discontinued on 11/28/24. He stated the resident kept the intravenous access line on left inner upper arm per Doctor's order. Only doctors may continue and discontinue IV . When asked if the IV access site is monitored, he stated, Nurses flush the Midline access and change the IV site dressing. In another interview with the DON on 12/11/24 at 3:59 PM, when asked regarding the IV access site and the antibiotic administered at the IV access site of Resident #198, he stated nurses change the dressing as ordered. When asked when the last administration of antibiotic was given to the IV access site, he responded, The last dose was administered on 11/28/24. When asked when the IV catheter was to be discontinued, since the IV antibiotic was discontinued a few weeks ago, he did not respond. He added that he spoke with Resident #198's physician, and he was not informed of why the IV catheter access site was kept after the IV antibiotic course was completed. He added that the Physician Assistant (PA) of Resident #198's Physician makes rounds to the facility every day, but no order was given to the facility regarding the discontinuation of IV catheter access. 40153 3. Record review revealed Resident #73 was admitted on [DATE] with diagnoses of Hyperlipemia and Major Depressive Disorder. The physician's order showed an order for Sertraline (depression medication) 50 milligrams one time a day, which was dated 08/09/24. Continued review of orders did not show an order to monitor the side effects of the Sertraline. The Annual MDS dated [DATE] revealed Resident #73 had a BIMS score of 13, which is cognitively intact. The Care Plan initiated on 05/23/24 showed that Resident #73 was on psychotropic medication Sertraline. Interventions are in place to monitor, record, and report to the doctor side effects and adverse reactions to the psychoactive medications. In an interview conducted on 12/12/24 at 12:05 PM, the facility's MDS Director stated that once a care plan for psychotropic medication is initiated, a batch order is generated to include monitoring of behaviors and side effects of the medicines. The staff will later document any side effects of the medications in the electronic system. The care plan will be reviewed to ensure that the orders are placed for monitoring of side effects and will be communicated to nursing. 36057 4. Review of Resident #77's clinical record documented an admission on 07/25/24 with no readmissions. The resident diagnoses included Tobacco Use, Cognitive Communication Deficit, Nicotine Dependence, Persistent Mood Disorders, Generalized Anxiety Disorder, and Unspecified Dementia. (continued on next page)

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	105089	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl at Fort Lauderdale Rehabilitation and Nursin	1701 NE 26th St Fort Lauderdale, FL 33305

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #77's MDS quarterly assessment dated [DATE] documented a BIMS score of 14 indicating the resident had no cognition impairment. Review of Resident #77's clinical record documented the Smoking assessment was conducted in for July, August and November 2024. . Review of a physician order dated 08/20/24 documented, Nicotine Patch 24 Hour 7 MG (milligrams) 24HR (hour). Apply 1 patch transdermally one time a day for Smoking Cessation and remove per schedule. Review of Resident #77's active care plan, titled, Resident has history smoking, initiated and updated on 11/20/24. The care plan interventions included Nicotine patch 24 hour 14 mg/24 hour one time a day for smoking cessation for two months . The care plan lacked written interventions related to monitoring of side effects of a psychotropic medication - Nicotine. Resident #77's clinical record did not include an active care plan related to the use of psychotropic medication (Nicotine). On 12/09/24 at 11:36 AM, during initial observational tour, an interview was conducted with Resident #77 who stated she had the oxygen on 24 hours a day seven (7) days a week. The resident stated she had Emphysema. On 12/10/24 at 4:35 PM, observation revealed Resident #77 in the smoking area with a lit cigarette in her hand. On 12/11/24 at 1:54 PM, an interview was conducted with Staff DD, LPN who stated Resident #77 continues to smoke but did not know how many cigarettes the resident was smoking. Staff DD stated the resident was getting a nicotine patch daily. Staff DD was asked how she would monitor the Nicotine medication side effects and stated she did vital signs daily. Staff DD stated that she would ask the Certified Nursing Assistants if the resident was having any problems like constipation and she would document it on a progress note. During the interview, Staff DD was asked regarding the resident's care plan interventions and replied she did not check the care plans, and added the Manager checks the care plans. A side-by-side and interview of Resident #77's care plan was conducted with Staff DD and replied, 'did not see any monitoring of the resident medication'. Staff DD stated they should be monitoring that. On 12/11/24 at 4:47 PM, an interview was conducted with the Consultant Pharmacist (CP) who was apprised of Resident #77 having a physician order for Nicotine patch and she was observed smoking on 12/10/24 late in the afternoon. The CP stated she did not know the resident was smoking and that the Nicotine patch is usually done for two months. The CP stated that they have lack of monitoring resident efficacy, and needs to have a behavior monitoring. During the interview, the CP stated that Nicotine patch was a psychotropic medication and she had not done a Gradual Dose Reduction (GDR) as per required. The CP stated Nicotine they needed to be monitoring it as a psychotropic medication for side effects and behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 9:25 AM, an interview was conducted with Resident #77 who stated that she was trying to stop smoking but it was hard to do. The resident stated the nurses were putting one Nicotine patch and rotate the arm, and did not remember if she was told for how long she was to wear the patch. The resident stated she smoked twice this week, one on yesterday evening (12/11/24) and on Tuesday. On 12/12/24 at 9:55 AM, an interview was conducted with Staff DD, LPN, who stated she had been putting one Nicotine patch seven (7) mg dosage to Resident #77 daily. On 12/12/24 10:39 AM, a joint interview was conducted with MDS Director and Staff CC, MDS Coordinator. The MDS Director stated last quarterly MDS assessment completed on 10/31/24 was coded for smoking but was not coded for psychotropic medication use. The MDS Director stated the resident's last smoking assessment was completed on 11/20/24 and that she was aware that the resident had a nicotine patch and continue to smoke regardless of using the patch. On 12/12/24 at 10:55 AM during an interview Staff CC, MDS coordinator, was asked who educated the nurses about resident's care plans and stated he did not know and added the care plan are available for them to see. 51663 5. Record review showed that Resident #86 was admitted on [DATE] with diagnosis of Major Depressive Disorder and seizure disorder. The MDS quarterly assessment dated [DATE] revealed the BIMS score was 00, which indicates severe cognitive impairment. Review of the physician orders indicated the following: Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 0.5 tablet by mouth at bedtime for Psychosis for 14 Days dated 10/03/24. A thorough review of the care plan dated 09/12/2024 indicated that Resident #86 is prone to side effects related to the use of: Antipsychotic, Antidepressant, Anticoagulant, Anticonvulsant, which need to be observed for potential side effects such as: hypotension, tachycardia, nausea, vomiting, diarrhea, blurred vision, chest pain, rash, drowsiness, lethargy. The facility failed to implement a Care Plan to monitor side effects for Antipsychotic medications.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to provide proper mouth care (Resident #40), failed to provide adequate grooming (Resident #36), and failed to provide assistance during dining (Residents #144, Resident #59, and Resident #311) for 5 of 39 sampled residents reviewed for Activities of Daily living (ADLs). The findings included: 1. Review of the facility's policy, titled, Activities of Daily Living (ADL), Supporting, dated 09/26/24 revealed the following: appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the residents in accordance with plan of care, including appropriate support and assistance with: Hygiene (dressing, bathing, grooming and oral care, and dining meals and snacks. Record review revealed Resident #311 was readmitted to the facility on [DATE] with diagnoses of type 2 Diabetes and Dementia. The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #311 has a Brief Interview of Mental Status (BIMS) score of 05, indicating moderate to severe cognitive impairment. Section GG for eating revealed Resident #311 needed partial to moderate assistance with eating. In an observation conducted on 12/11/24 at 8:45 AM, Resident #311 was in the room with her breakfast tray on the bedside table. No staff was noted in the room at the time of this observation. At 9:00 AM, 15 minutes later, there was no staff in the room, and the breakfast tray was still untouched. At 9:05 AM, 20 minutes later, Staff C, certified Nursing Assistant (CNA), came into the room. At 9:10 AM, she started feeding Resident #311, and at 9:12 AM, Staff C left the room. Continued observation at 9:20 AM showed that Resident #311 ate 25% of her meal. In an interview conducted on 12/12/24 at 12:05 PM, the MDS Director stated that when a resident is coded for partial assist to moderate assist, they need assistance with feeding and that the staff needs to be in the room for encouragement or queuing if needed. Staff may need to help the resident sometimes if they cannot eat on their own. 38349 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility policy and procedure, titled, Activities of Daily Living (ADL), provided by the Director of Nursing (DON) published 09/26/24, documented in the Policy Statement: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily (ADLs). Residents who are unable to carry out activities of daily (ADLs) independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming and oral care); .6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. 7. The resident's response to interventions will be monitored, evaluated and revises as appropriate. Record review documented Resident #40 was admitted to the facility on [DATE] with diagnoses which included Cerebral Atherosclerosis, Adult Failure to Thrive, Diabetes Mellitus Type II, Hypertension, Dementia, Major Depressive Disorder and Cerebral Infarction. She had a BIMS score of 5 indicating severe cognitive impairment. On 09/25/24, the Physician's Order documented Regular diet, Mechanically Altered Chopped texture, Thin Liquids consistency, with small portions for nutrition. This indicated the resident was capable on consuming liquids/water for Hydration. On 04/22/24, the Complete Blood Count (CBC) with differential lab work (indicative of Dehydration) documented Potassium 4.0, Chloride 109 high, Hemoglobin 9.1 low, Hematocrit 28.2 low, Blood Urea Nitrogen (BUN) 24, Bicarbonate 22 and Osmolality calculated 292. On 10/18/24, the Complete Blood Count (CBC) with differential lab work (indicative of Dehydration) subsequently documented Potassium 5.3, Chloride 116 high, Hemoglobin 11.6 low, Hematocrit 37.3, Blood Urea Nitrogen (BUN) 53 high, Bicarbonate 15 and Osmolality calculated 306.6. Record review of the Resident #40's Monthly Personal Hygiene CNA ADL (Activities of Daily Living) Task Flowsheet Record dated 11/28/24 through 12/11/24 revealed the resident's (ADL)s for Personal and Oral Hygiene indicated the resident required dependent-helper does all of the effort. Resident does none of the effort to complete the activity ., during the day and evening shifts. Record review of the Resident #40's care plan initiated 09/23/23 and revised 06/17/24 indicated Focus: Resident is at risk for Oral/Dental health problems .Interventions: Provide mouth care as per ADL personal hygiene. Goal: The resident will comply with mouth care at least daily through review date. Further record review of the Resident #40's care plan initiated and revised 11/26/24 indicated Focus: Resident is at nutritional risk: . diagnosis of Cerebral Atherosclerosis. Average meal intake < 25% comfort care, Terminal Condition, Total Dependence of ADL. Interventions: Glycerine swabs to alleviate symptoms of Dehydration .Provide favorite foods and beverages Provide mouth care as needed Goal: Resident #40 will be comfortable with food/fluids provided. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident #40 conducted on 12/09/24 at 11:11 AM, she was observed resting in bed and breathing with her mouth wide open in which her mouth, lips, teeth, tongue and gums were all dry and non-moist in appearance. It was observed that there was also some dry, cracked areas on the edges of her lips and mouth, indicative of improper mouth care. There was no water pitcher, no covered cup of water, nor any Glycerin moisture stick packs noted/kept at her bedside. Photographic Evidence Obtained. On 12/09/24 at 4:23 PM, Resident #40 was still observed resting in bed and breathing with her mouth wide open with her mouth, lips, teeth, tongue and gums all remaining dry and non-moist, in appearance. It was still observed that there was also some dry, cracked areas on the edges of her lips and mouth, and still with no water pitcher, no covered cup of water, nor any Glycerin moisture stick packs noted/kept at her bedside. On 12/10/24 at 11:32 AM, Resident #40 was again observed resting in bed and breathing with her mouth wide open with her mouth, lips, teeth, tongue and gums all remaining dry and non-moist, in appearance. It was still observed that there was also some dry, cracked areas on the edges of her lips and mouth, and still with no water pitcher, no covered cup of water, nor any Glycerin moisture stick packs noted/kept at her bedside. An interview was conducted on 12/11/24 at 11:50 AM with Staff C, Certified Nursing Assistant (CNA), regarding the appearance and care of Resident #40's mouth. Staff C revealed she uses the small, dry mouth sponges which she dips and wets it in either some water or mouth wash, instead of using the Glycerine swabs to clean the resident's mouth. The CNA acknowledged that there was no water pitcher nor cup of water at the resident's bedside, and she also acknowledged that the resident's lips were dry at the time. An interview was conducted with Staff S, Licensed Practical Nurse (LPN), on 12/11/24 at 1:22 PM, regarding the appearance and care of Resident #40's mouth. Staff S stated the CNAs are to use the Glycerin swabs for cleaning the resident's mouth during AM care and throughout the shift as needed. She stated she did not know why there were no Glycerine swabs kept at the resident's bedside for regular routine mouth care. The nurse acknowledged the resident's mouth did appear to be a little dry, at the time. An interview was conducted with Staff T, LPN/Unit Manager, regarding the appearance and care of Resident #40's mouth. Staff T stated that the CNAs are to provide regular/daily mouth care to this resident during ADL care, before and after meals and as needed. She added that Resident #40 should have a pitcher or a cup of water at her bedside. She said that she did not know why there were no Glycerine swabs, nor water at the resident's bedside for mouth care. Staff T acknowledged that Resident #40's lips did not look moist, at that time. There was no documentation in the nursing progress notes for the past four (4) weeks dated 11/12/24 to 12/10/24, referencing that the resident was receiving proper and regular ADL personal hygiene mouth care. There were no observations noted to indicate that the facility had been regularly providing proper mouth care for Resident #40, as evidenced by the fact that the Resident #40's mouth, lips, teeth, tongue and gums still appeared to remain dry, cracked and non-moistened, at various random times, throughout the survey. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON recognized and acknowledged on 12/11/24 at 5:11 PM that Resident #40 was to be provided proper and adequate assistance to maintain ADLs for oral hygiene; and this was not done. 50895 3. Record review revealed Resident #36 was admitted on [DATE] for Coronary Heart Disease, Hypertension, Benign Prostatic Hyperplasia, Renal Insufficiency, Diabetes Mellitus, Hyperlipidemia, and Depression. The BIMS score, per Minimum Data Set assessment dated [DATE], was 6 indicating severe cognitive impairment. Record review of Resident #36's baseline care plan, created on 11/01/24 and completed on 11/05/24, noted this resident required partial to moderate assistance with personal hygiene activities. The focus of the care plan dated 11/06/24 noted the resident had an ADL self-care performance deficit related to activity intolerance and limited mobility. The goals of the care plan updated on 11/22/24 were to improve the current level of function in ADLs. This included personal hygiene. Interventions included therapeutic exercises, therapeutic activities, and ADL retraining. In an interview with Resident #36 on 12/09/24 at 12:18 PM in his room, Resident #36 rubbed his chin and said that he didn't like his beard. He voiced his preference was to be shaved. When asked how his facial hair used to be before he was admitted to the facility, Resident #36 said that he usually went to the barber and that the barber shaved it off. He verbalized that he felt like a bum. Resident #36 was observed on 12/10/24 at 2:37 PM in his room. His facial hair was approximately 3/4 inch in length above his lip, on his chin, and along the lower sides of his face. In a phone interview conducted on 12/10/24 at 4:15 PM with this resident's 1st contact, step-daughter, revealed that a female employee at the facility provided shaving services for Resident #36 in the past. The 1st contact said that she was at the facility earlier that day and that she told her father that his shaver was in the closet. She shared that she reminded him he should ask someone to help him shave. An interview was conducted with LPN, Staff BB, on 12/12/24 at 3:01 PM. Staff BB stated she provided care for Resident #36 during the day shift on 12/12/24. When asked what the process was for shaving residents, Staff BB stated an aide on any shift could assist a resident with shaving. She stated the aide always checks with the LPN or RN (Registered Nurse) prior to shaving so that the resident can be assessed for safety reasons. She explained the nurse reviews the medications and the integrity of the skin during the assessment. 51663 4. Record review showed Resident #144 was admitted on [DATE] with diagnosis of Epilepsy and Hypothyroidism. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the BIMS) score is 7 indicating moderate cognitive impairment. Section GG of the MDS showed Resident #144 needs setup or cleanup assistance during dining. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Order Summary Report showed the following: an order dated 09/30/24 for regular diet regular texture, thin liquid consistency, fortified foods. Review of the Certified Nursing Assistant (CNA) tasks stated the following: Eating: (3) Partial / moderate assistance required X 1 Staff dated 10/12/24. A thorough review of Resident #144's care plan dated 09/29/24 stated the following: Monitor oral intake of food and fluid and provide fortified foods (fortified cereal w/ breakfast-487 calories/8 grams of protein, high calorie pudding w/ lunch and dinner-140 kcal/0 g protein). In an observation conducted on 12/09/24 at 1:30 PM, the surveyor observed Resident #144 in his room attempting to eat his regular diet lunch from the tray without assistance of staff in the room. Resident #144 had a towel on his lap that was filled with food. In an observation conducted on 12/10/24 at 1:35PM, the surveyor observed Resident #144 in his room attempting to feed himself the regular diet food that was on his tray without assistance with most of his food on the towel on his lap. In an interview conducted on 12/10/24 at 3:30 PM with Staff X, Certified Nurse Assistant/CNA, stated that she's been working at this facility full time for one year. Staff X said that she is familiar with Resident #144 and the resident can drink on his own but needs assistance with feeding. She additionally said that when she is assigned to this particular resident, she feeds him. 5. Record review showed Resident #59 was admitted on [DATE] with diagnosis of Age-related physical debility. The MDS quarterly assessment dated [DATE] revealed the BIMS score was 6 indicating severe cognitive impairment. Section GG of the MDS showed that Resident #59 needs setup or cleanup assistance during dining. In an observation conducted on 12/10/24 at 1:35PM, the surveyor was desperately called by Resident #59 asking for help to eat. Resident #59 was observed with her milk all over her face, neck and clothes. The surveyor proceeded to call a staff member. Staff A, Registered Nurse Manager was found in the hallway and stated this particular resident usually eats alone.

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50370

Based on observations, interviews and record reviews, the facility failed to ensure appropriate urinary catheter care for 1 of 1 sampled resident reviewed for urinary catheter care, Resident #102.

The finding included:

Review of the facility's policy, titled, Catheter Care Urinary, published on 10/07/24, revealed that the purpose of urinary catheter care is to prevent urinary catheter-associated complications, including urinary tract infections. Under infection control on page 1, statement #2, revealed that catheter tubing and drainage bag are kept off the floor. Under the complications on page 2, statement #1, revealed to observe the resident for complications associated with urinary catheters; and to report unusual findings to the physician or supervisor immediately if, urine has unusual appearance (i.e., color, blood, etc.). Routine Perineal hygiene on page 3, under statement 18, revealed that after urinary perineal care is done, and disposable items were discarded, staff must remove gloves, and wash and dry hands thoroughly.

Record review revealed Resident #102 was admitted on [DATE] with diagnoses that included Atrial Fibrillation, Type I Diabetes Mellitus, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, and Chronic Kidney Disease.

Review of Minimum Data Set (MDS) assessment, dated 11/20/24, Section C, revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating Resident #102 had moderate cognitive impairment.

The MDS' Section GG dated 09/26/24, revealed Resident #102's ability to 'come to a standing position from sitting in a chair', as the resident needed partial to moderate assistance.

Section E, regarding chair/bed-to-chair transfer, revealed Resident #102 needed partial to moderate assistance during transfer to and from a bed to a chair (or wheelchair).

Review of Medication Administration Record (MAR), dated 08/24/24, revealed Foley (urinary catheter, inventor's name of a flexible tube inserted into the bladder to drain urine) catheter care every shift PRN (as needed). Further review revealed that from 12/01/24 until 12/10/24, no urinary catheter care was documented as performed, even when resident was complaining of blood-tinged urine from the night of 12/08/24 until the evening of 12/10/24.

Further record review of MAR, dated 08/26/24, revealed to 'change urinary drain bag when there are signs and symptoms of blockage, leakage, obstruction or infection as needed, every 8 hours as needed daily, to maintain catheter patency'. From 12/01/24 until 12/10/24, there were no nurses' initials recorded on MAR that indicated the urinary drainage bag was not changed even when resident's urine was red tinged.

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of quarterly nursing care plan dated 09/11/24 revealed to monitor / record / report to Medical Doctor (MD) for signs and symptoms of Urinary Tract Infection (UTI), like blood-tinged urine, cloudiness, and deepening of urine color. Review of the MAR from 12/01/24 to 12/10/24 noted there were no recorded nurses initials and blood tinged-colored urine recorded on the MAR or notes, indicating the nurses did not monitor the Foley for red or blood-tinged urine as reported by resident since the night of 12/08/24.

Additional nursing care plan dated 09/11/24 revealed to practice Enhanced-Barrier Precautions: wear gown and gloves during assistance with dressing, bathing, transferring, hygiene, changing linens, changing briefs & toileting, and catheter care.

Review of the MAR, dated 10/19/24, revealed to irrigate foley catheter with 30-50 mL sterile Normal Saline as needed for occlusion, and as needed for obstruction. From 12/01/24 until 12/10/24, there were no recorded nurses' initials on the MAR or notes, indicating the nurses did not irrigate the urinary tubing even when resident was complaining of blood-tinged urinary tubing.

During observation on 12/09/04 at 11:30 AM, Resident #102 was sitting in the wheelchair, with legs down, both feet on the wheelchair pedals with no elevation, and the urine tubing had blood-tinged color.

During another observation on 12/10/24 at 10:00 AM, Resident #102 in the wheelchair with legs down on foot pedals, no elevation, and resident's legs covered with white blanket. The urinary tubing was observed to have a blood-tinged color.

In another observation on 12/10/04 at 3:00 PM, Resident #102 stated he has not seen a doctor for a month, his legs are getting more swollen, and staff are not elevating legs in bed or in wheelchair. He stated that the urine color on his tubing is still red, and he informed the nurse, but nurses did not irrigate.

During a perineal care observation on 12/12/24 at 9:30 AM, Staff K, Certified Nursing Assistant (CNA), was wearing gloves on both hands, and stated urinary tubing care was done. Staff K was observed wearing a blue Personal Protective Equipment (PPE) gown. Staff K was putting a pair of shorts on the resident's right leg, with the urinary tubing observed to have red-tinged color and the urinary bag was hanging on the left side of the bed. The urinary privacy blue cover was hanging a few inches away from the urinary bag.

Staff K continued with putting on resident's short, then afterwards, touched the green chucks (disposable impermeable pads) under the resident's bottom. She went to the other side of bed and touched her hair, touched the resident's top drawer, and touched the resident's wheelchair handle, with the same set of gloves. Staff K removed the square bath basin from the resident's bedside table and washed it in resident's bathroom using the same gloves. She dried the square bath basin, went back inside the resident's room, opened the drawer of resident's side table and put the square bath basin inside the drawer. Staff K was still wearing the same set of gloves, when she touched the resident's socks on both feet, grabbed the orange shirt and put it on the resident.

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Staff K proceeded to move the wheelchair, which was 2 feet away from the left foot part of resident's bed, and wheeled it next to resident's bed closer to the middle. Using the same set of gloves, she removed the urine bag hanging on the side of the bed and placed it on the floor. She stated that the urine bag must be on the floor so resident will not accidentally trip on it, while resident is transferring from bed to a wheelchair. The urinary bag had no privacy protection when it was placed on the floor by Staff K.

Using the same gloves, Staff K continued holding the back handle of the wheelchair while the resident was trying to get out of bed. Then at 9:52 AM, Staff K removed her blue PPE gown and removed her blue gloves. She stepped out of the room and performed ABHR (alcohol-based hand rub) at 9:54 AM.

In an interview with Staff P, CNA, on 12/11/24 at 9:32 AM, she stated she is responsible for checking the urinary tubing of residents. She checks if the tubing is draining, secured on resident's leg, and the urinary bag has a privacy covering. She makes sure the urinary tubing is not bloody or cloudy, and if she sees these colors, she lets the nurse know. She added that she makes sure to clean the connection to the urinary opening of a male resident, free from any crusts, and for a female resident, she makes sure she wipes it clean from the vaginal opening downward. She uses gentle cleaning baby wipes to perform urinary catheter tubing care. She rinses the catheter, then dries it well. She added that she empties the urinary bag when needed and document the amount in the CNA task field of the electronic health record. When asked how often she checks on residents with urinary catheter, she stated that she frequently checks the urinary catheter every time she passes by the resident. Staff P added she makes sure the urinary tubing is securely attached to resident on every visit she makes.

In an interview with Resident #102 on 12/11/24 at 9:52 AM, he stated that no staff member saw him and checked his urinary bag for the whole night. The surveyor noticed reddish colored urinary tubing. The tubing remained reddish colored for the whole day during the survey. Resident #102 stated that he told a nurse who works from 3:00 PM until nighttime to check on his urinary catheter tubing. Resident added that after he told her, the nurse did not come back.

In another interview with Staff P, CNA on 12/11/24 at 10:37 AM, she stated the CNAs document the personal care they performed on resident like urinary care and applying barrier cream. She stated the care in Medication Administration Record (MAR) is signed by the CNA using initials only. This Staff showed this surveyor that in facility's computer there is no way for them (CNAs) to record if urinary catheter tubing is cloudy or bloody, but she as a CNA will inform the nurse, if she sees these colors or conditions.

In an interview with Staff N, Registered Nurse (RN), on 12/11/24 at 10:49 AM, when asked regarding the resident's red colored urine, she stated she never asked the resident regarding red colored urine in urinary catheter tubing and had never flushed the resident's urinary catheter. When asked why, she stated she had never observed blood-tinged urine or red colored urine in Resident #102's urinary catheter tubing. When asked if she had read the nursing care plan regarding blood-tinged urine, or reviewed Resident #102's MAR, she stated she did not read the care plan or the MAR regarding Resident #102's urinary catheter tubing. When asked why, she did not respond.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pearl at Fort Lauderdale Rehabilitation and Nursin		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 NE 26th St Fort Lauderdale, FL 33305	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff O, RN Unit Manager, on 12/11/24 at 10:58 AM, she stated nurses document the findings of bloody urine in their nursing progress notes. When asked if it was also recorded on the PRN (as needed) in MAR, she stated, nurses document it there too. Staff O added, The facility's nurses document in the MAR the urinary care they performed on residents, using initials only, on the indicated shift. In an interview with the Director of Nursing (DON) on 12/11/24 at 4:20 PM, he stated, The urinary catheter care is performed by CNAs and documented on the CNA task form. The CNAs perform the urinary tubing care every shift. The urinary catheter care includes checking the urinary bag, securing bag, providing urinary bag with privacy covering, checking the urinary output, and making sure the urinary tubing is attached securely to resident. When there is cloudy or bloody urine output observed, the CNA reports it to the nurse right away. The nurse is responsible for documenting the findings of cloudy or bloody urine in progress notes or MAR. The nurse reports the bloody or cloudy urine findings to the resident's physician.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews and record review, the facility failed to ensure that the facility's scales were calibrated for accuracy and failed to ensure that nutritional supplements were provided in a timely manner for 2 of 10 sampled residents reviewed for nutrition, Resident #100 and Resident #311. The findings included: Review of the facility's policy, titled, Interdisciplinary Management and Prevention of Significant Weight Loss of Nursing Facility Residents, dated 09/20/22, documented in part the following: the purpose is to provide guidelines for detection of early unplanned weight loss, which includes communication and appropriate action by the team to maintain acceptable parameters of nutritional status of nursing facility residents. Residents who lose weight will be identified and managed in a timely manner. Reweigh residents with significant weight discrepancies within 24 hours if needed and monitor all interventions for efficacy and feasibility. Further review of the policy showed that preventative maintenance and calibration of scales should be performed by the engineering department or outside vendors as applicable. 1. Record review revealed Resident #100 was readmitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease and Anemia. The Quarterly Minimum Data Set, dated dated [DATE], showed Resident #100 has a Bried Interview of Mental Status (BIMS) score of 12, which is moderate cognitive impairment. Review of the weight logs revealed the following weights for Resident #100: On 08/06/24 recorded weight of 142.8 pounds. On 09/09/24 recorded weight of 132.0 pounds. On 10/09/24 recorded weight of 118.0 pounds. On 11/05/24 recorded weight of 126 pounds. On 12/03/24 recorded weight of 127.6 pounds. This showed a weight loss of 7.5% in one month from 08/06/24 to 09/09/24 and a 17% weight loss of 17% in two months from 08/06/24 to 10/09/24. Review of the Dietary progress note dated 10/07/24 showed that Resident #100 had decreased meal intake and a weight loss of 8%. Resident #100 was on fortified foods and receiving Glucerna (nutritional supplement) once a day. In this note, the facility's Dietitian updated the food preferences and liberalized the diet but did not at this time increase the nutritional supplements from once a day or add an additional nutritional supplement, as monitoring to see if the resident liked the supplement. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of the Dietary note dated 10/22/24 showed that the facility's Dietitian increased the Glucerna supplements from once a day to three times a day. The increase was made approximately 40 days after the first weight loss of 7.5% was identified on 09/09/24.

Review of the dietary note dated 11/13/24 showed the RD documented the following: in 30 days there is 7% significant gain, in 90 days there is 12% significant and in 180 days there is 15% significant.

An interview was conducted on 12/12/24 at 1:08 PM with Staff W, the Registered Dietitian, who stated that for any severe or significant weight loss, she would try and follow up with the resident as soon as possible and provide additional interventions. When asked why the Glucerna supplements were only increased to 3 times a day on 10/22/24 and not earlier, she said that the food approach is tried first. If that does not work, then she will add nutritional supplements as needed. According to Staff W, Resident #100's diet was liberalized as an intervention for significant weight loss.

The record showed that the resident was slowly gaining weight. Interventions were in place.

2. Record review revealed Resident #311 was readmitted to the facility on [DATE] with diagnoses of Type 2 Diabetes, Acute Neurologic Dysphagia, Anemia, Subdural Hemorrhage, and Dementia. The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #311 has a Brief Interview of Mental Status (BIMS) score of 05 indicating severe cognitive impairment. Section GG for eating revealed that Resident #311 needs partial to moderate assistance with eating.

Review of the weight log for Resident #311 was as following:

On 04/03/24, a weight of 165.0 pounds.

On 08/22/24, a weight of 176.4 pounds.

On 09/09/24, a weight of 162 pounds.

On 10/04/24, a weight of 155 pounds.

On 12/03/24, a weight of 152.4 pounds.

This showed a 13.6% weight loss in less than 6 months, from 08/22/24 to 12/03/24.

Review of the Dietary note dated 10/09/24 showed a possible weight discrepancy but no reweight was obtained for Resident #311. Furter review of the Dietary progress notes showed that the 13.6% weight loss was not addressed after it was identified on 12/03/24.

An interview was conducted on 12/12/24 at 1:08 PM with Staff W, the Registered Dietitian, who stated that if any discrepancies with weights, she would ask for a reweight as soon as possible. When asked as to why the 13.6% weight loss was not addressed after 12/03/24, she did not have an answer.

Various observations during the survey showed the resident was receiving her mighty shakes. Interventions were in place.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51663 3. Observation conducted on 12/10/24 at 10:30 AM revealed that the Stationery Scales from the South Unit, [NAME] Unit, North Unit and East Unit respectively were dated as follows: Next due date for the Standing scale calibration were: 08/2024, 08/2024, 05/2024, 08/2024. It was also observed that there was a Standing Scale in the [NAME] Unit that had a due date for calibration of: 08/2024. Observation conducted on 12/10/24 at 2:10PM revealed that the East Wing 4 Hoyer lift, the South Wing 3 Hoyer Lift and the 2 Hoyer Lift respectively had stickers that had no dates under the sections: completed and next due or tech. An interview was conducted on 12/12/24 at 11:35AM with the Director of Plan Operations, who stated that he's been working in this facility for a little over a year. He stated that they have a subcontracted private company that comes twice a year that is in charge of calibrating the scales and that he checks the scales every other month to make sure that everything works properly. The Director of Plan Operations stated the facility had 7 Hoyer Lifts and 4 Stationary Scales, and also that the due date that is indicated in the stickers means that the service is supposed to be conducted by that date. An observation was conducted on 12/12/24 at 11:45 AM with the Director of Plan Operations who was taken to one of the scale rooms in the East Wing and was shown the missing due date for calibration on the label. In this observation, he further explained that he did see the staff from outside private companies calibrating the scales. They usually come to calibrate the scales and send the paperwork to corporate and because he is fairly new, they probably didn't have his email and sent the report to the old Director. He further stated that the outside company is the one responsible for updating the dates on the machines. At this time, the Director of Plant Operations stated that he had a log associated mostly with the Hoyer Lifts and not with the Scales, and the process that he follows when he checks the scales every month is the following: he puts a certain weight on the scale and if it's not accurate he calls the outside company. He also indicated that if a staff member finds a discrepancy while weighing a resident, the staff inform, him and most of the time it's a simple battery issue. Review of the outside company showed that they conducted a visit on 08/26/24, which showed only the location of the scaled was reported and the type of scales that were calibrated, and that the next inspection due date was 11/2024. When asked as to why the outside company did not come to inspect the scales on 11/2024, the Director of Plans of Operations did not have an answer. The Director of Plant Operations could not provide a contract.

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	105089	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl at Fort Lauderdale Rehabilitation and Nursin	1701 NE 26th St Fort Lauderdale, FL 33305

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policies and procedures, observation, record review and interview, the facility failed to obtain a current specified physician's order to address the care and maintenance of an Intravenous (IV) / Peripherally Inserted Central Catheter (PICC) line and to label and date the resident's PICC line site dressing for 3 of 3 sampled residents observed, Resident #308, Resident #185 and Resident #198. The findings included: Record review of the facility policy and procedure, titled, Peripheral and Midline IV Dressing Changes, provided by the Director of Nursing (DON), published 09/26/24 documented in the Policy Statement: Purpose: This purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. General Guidelines: 1. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g. damp, loosened or visibly soiled) 4. Change the dressing if it becomes damp, loosened or visibly soiled and: a. at least every 7 days for Transparent Semi-permeable Membrane (TSM) dressing .c. Immediately if the dressing or site appears compromised .6. Assess the peripheral/midline access device at least every 4 hours (every 1-2 hours for residents with cognitive impairment.) .c. Assess the patency of the vascular access device; d. Palpate and inspect the skin, dressing and securement device for signs of complications .7. Assess the integrity of securement devices with each dressing change .Documentation: 1. The following should be documented in the resident's medical record: a. Date, time, type of dressing and reason for dressing change. b. Any complications/intervention related to insertion site or surrounding area. c. Resident's response to procedure . 1. Record review revealed Resident #308 was admitted to the facility on [DATE] with diagnoses that included Fracture of Left Shoulder Girdle Part and Displaced Fracture of Upper End of Left Humerus, Adjustment Disorder, Diabetes Mellitus Type II, Hypertension, Atherosclerotic Heart Disease and Chronic Kidney Disease Stage 3. The documented Brief Interview Mental Status (BIM) score was 10 indicating moderate impairment. Resident #308 was subsequently transferred to the hospital on 12/11/24 for further evaluation for possible aspiration, following a lunch meal. Review of the record revealed that on 11/29/24, the physician's order documented for the insertion of the IV PICC line. There was no physician's order written to specify the details for the care and maintenance for Resident# 308's IV PICC line, to include: regular dressing changes and flushing of the line to maintain patency. There were no documented current indications for use of the resident's PICC line. During an observation of Resident #308 conducted on 12/09/24 at 12:27 PM, the resident was observed with a right arm PICC line in place. Observation of the PICC line dressing revealed there was no date and time noted, with illegible writing noted on the old, stained, dingy-colored PICC line dressing tape which was also observed to be peeling off and loosened at the edges of the PICC line dressing and not securely attached. Photographic Evidence Obtained. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/24 at 3:27 PM, Resident #308 was observed with his right arm PICC line in place with no date and time noted on the PICC line dressing, and with no physician's order for the maintenance of the PICC line. On 12/10/24 at 10:18 AM, Resident #308 was observed with his right arm PICC line in place with no date and time noted on the PICC line dressing, and with no physician's order for the maintenance of the PICC line. On 12/10/24 at 4:00 PM, Resident #308 was observed with his right arm PICC line in place with no date and time noted on the PICC line dressing, and with no physician's order for the maintenance of the PICC line. On 12/11/24 at 12:17 PM, Resident #308 was again observed with his right arm PICC line in place with no date and time noted on the PICC line dressing, and with no physician's order for the maintenance of the PICC line. An interview was conducted with Staff T, LPN, on 12/11/24 at 12:16 PM, regarding Resident #308's right arm PICC line and the current status of the dressing. She acknowledged that the dressing had no date or time on it. She also revealed that she did not know whether there was an order for the PICC line dressing to be changed, nor did she know if the PICC line dressing was being changed regularly by nursing staff. An interview was conducted with Staff V, Registered Nurse / Unit Manager (RN/UM), on 12/11/24 or 12:43 PM, regarding Resident #308's right arm PICC line and the current status of the dressing. She acknowledged that the PICC line dressing should be dated and maintained but she did not know if this was being done. Staff V acknowledged there was no physician order for care and maintenance of the PICC line. There was no care plan in place for Resident #308's IV PICC and no documentation noted in the nursing notes from 11/22/24 through 12/10/24 regarding the presence or existence of the resident's right arm PICC line, by facility staff. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) lacked evidence of care performance of the PICC line by facility staff. The DON acknowledged that Resident #308 had an IV PICC line in place. He recognized that there was no date, initial nor time on either of the resident's IV PICC dressing, nor were there any physician orders in place to address the specified care and maintenance of the IV PICC line. 2. Record review revealed Resident #185 was readmitted to the facility on [DATE] with diagnoses that included Disruption or Dehiscence of Closure of Internal Operation (Surgical Wound), Displaced Intertrochanteric Fracture of Femur and of Coccyx, Dysphagia, Major Depressive Disorder, Diabetes Mellitus Type II, Hypertension, Atherosclerotic Heart Disease, Atrial Fibrillation and Chronic Hepatitis. The documented BIMS score was 15, indicating intact cognition. Review of the 3008 Agency for Healthcare Administration (AHCA) Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form, date 11/08/24, documented the resident was transferred from the hospital and admitted to the facility with an IV PICC in place in her right upper arm. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/08/24, the physician's order documented, Monitor IV PICC line site every shift .for 39 days. There were no current physician's orders written to specify the details to address the care and maintenance for Resident #185's IV PICC line, to include: regular dressing changes and flushing of the line to maintain patency. On 12/09/24 at 1:30 PM, Resident #185 was observed with a right upper arm PICC line in place. There was no date and time noted on the old, stained, dingy-colored PICC line dressing tape which was also observed to be peeling off and loosened at the edges of the PICC line dressing and not securely attached. Photographic Evidence Obtained. On 12/09/24 at 1:30 PM, Resident #185 was observed as having a PICC line in her right arm with no date and time noted on the PICC line dressing or tape. On 12/10/24 at 11:56 AM, Resident #185 was observed as having a PICC line in her right arm with no date and time noted on the PICC line dressing or tape. On 12/10/24 at 4:20 PM, Resident #185 was observed as having a PICC line in her right arm with no date and time noted on the PICC line dressing or tape. On 12/11/24 at 11:41 AM, Resident #185 was again observed as having a PICC line in her right arm with no date and time noted on the PICC line dressing or tape. An interview was conducted with Staff S, LPN, on 12/11/24 at 1:16 PM, regarding Resident #185's right arm PICC line and the current status of the dressing. Staff S acknowledged there was an order to monitor the dressing, but no specifics as to when to change the dressing and flush it for maintenance, patency and care. Staff S added that she did not know, if the PICC line dressing was being changed by nursing staff. An interview was conducted with Staff T, LPN/UM South wing, on 12/11/24 at 4:21 PM regarding Resident #185's right arm PICC line and the current status of the dressing. Staff T acknowledged there was no current, specific order for the PICC line dressing to be changed. Staff T added that she did not know if the PICC dressing was being changed by nursing staff. There was no care plan in place for Resident #185's IV PICC. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked evidence of a documented initial / signed evidence of current care performance to address the PICC line site, by facility staff. The record lacked evidence of Resident #185's skin being assessed with her PICC line dressings being changed by the Wound Care Nurse, until after surveyor intervention. The DON acknowledged that Resident # 185 had an IV PICC line in place. He recognized that there was no date, initial nor time on either of the resident's IV PICC dressing, nor were there any physician orders in place to address the specified care and maintenance of the IV PICC line. 50370 (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Record review revealed Resident #198 was admitted on [DATE] with diagnoses that included Hyperlipidemia, Type 2 Diabetes Mellitus with Foot Ulcer, Benign Prostatic Hyperplasia, Chronic Viral Hepatitis, Atherosclerotic Heart Disease, and Venous Insufficiency. Review of the Minimum Data Set (MDS) assessment revealed a score of 13, indicating mild cognitive impairment. Review of physician orders dated 11/11/24 documented to give meropenem I Gm. (gram) into venous catheter every 12 hours. Review of the nursing care plan dated 11/13/24 revealed that if an IV (intravenous) is infiltrated: stop infusion and thoroughly examine the site. If the catheter appears to be lodged in the tissues, an attempt to aspirate any fluid remaining in the catheter can be made to lessen the amount of drug at the site. After removing the cannula, elevate the affected arm, notify the physician (for large infiltrations and extravasations), and apply cool compresses (warm, if [NAME] alkaloids are involved). Review of the Medication Administration Record (MAR), dated 11/14/24, revealed to flush left upper arm midline catheter every shift. The same MAR revealed that nurses documented their initials from 12/01/24 until 12/10/24 indicating flushings of midline catheter on these dates were performed. Additional review of MAR with a date of 11/14/24, revealed to perform midline to left arm check every shift and code with the following: 1= no problem, 2= edema, 3= redness, 4=pain. Review of MAR from 12/01/24 until 12/10/24 revealed that nurses put their initials, but no codes were documented on all these dates, indicating the midline left arm checked was not done per order. Further review of MAR dated 11/14/24 revealed an order to change the midline IV dressing to left upper arm as needed. From 12/01/24 until 12/11/24, there were no documented nurses' initials which indicated the nurses did not change the dressing as needed. During observation on 12/09/24 at 9:35 AM, Resident #198 was sitting in bed with a left arm IV catheter dressing with no date and nurse's initials markings. The square surrounding area had a brownish coloration and the Tegaderm (transparent medical dressing) shield was loosely covering the bottom and sides of white gauze dressing. When asked if he was receiving medication through the IV catheter, Resident #198 replied, No. During another observation and interview on 12/11/24 at 9:30 AM, Resident#198's IV dressing were observed to be loose, and the surrounding area had reddish fluid drainage on the dressing and the surrounding areas, that smelled like blood. Resident #198 stated the IV antibiotic was discontinued a long time ago. When asked why he still has the IV catheter on left arm, he stated he did not know, and no one informed him of why the IV catheter was in his left arm. When asked if the staff were checking on the catheter, he stated, not recently. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 12/11/24 at 3:59 PM. When asked regarding the IV catheter access site and the antibiotic administered at the IV access site of Resident #198, the DON stated the nurses change the dressing as ordered. When asked when the last administration of antibiotic was given through the IV access site, he responded, the last dose was administered on 11/28/24. When asked when the IV catheter was to be discontinued, since the IV antibiotic course was completed a few weeks ago, he did not respond. He added that he spoke with Resident #198's Physician, and he was not informed of why the IV catheter access site was kept for few more weeks after the IV antibiotic course was completed. He stated the Physician Assistant (PA) of Resident #198's Physician makes facility rounds everyday, but no order was given to the facility regarding the discontinuation of IV catheter access for Resident #198.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38349

Based on review of policy and procedure, observation, record review and interview, the facility failed to ensure that it obtained current physician's orders for Oxygen therapy administration for 1 of 6 sampled residents observed receiving continuous Oxygen on the South wing, Resident #309; and failed to monitor residents receiving Nebulizer treatments, according to standards of care, for 1 of 1 sampled resident, Resident #120.

The findings included:

1. Review of the policy and procedure, titled, Oxygen Administration, provided by the Director of Nursing (DON), published 10/07/24, documented in the Policy Statement: Purpose: The purpose of this procedure is to provide guidelines for safe Oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for Oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident .Assessment: Before administering Oxygen, and while the resident is receiving Oxygen therapy, assess for the following: 1. Signs or symptoms of Cyanosis .2. Signs or symptoms of Hypoxia .3. Signs or symptoms of Oxygen toxicity .4. Vital Signs, 5. Lung sounds, 6. Arterial Blood Gases and Oxygen saturation, if applicable; .Documentation: After completing the Oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of Oxygen flow, route, and rationale. 4. The frequency and duration of the treatment. 5. The reason for as needed (p.r.n.) administration. 6. All assessment data obtained before, during, and after the procedure. 7. How the resident tolerated the procedure.

Record review revealed Resident #309 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease, Hypertension and Atherosclerotic Heart Disease. The documented Brief Interview Mental Status (BIM) score was 13, indicating intact cognition.

Record review of the Resident #309's care plan initiated and revised 08/23/24 indicated Focus: The resident has Oxygen Therapy. Interventions: Auscultate lung sounds Change nasal cannula tubing as needed Monitor Oxygen saturation every shift. Oxygen therapy as per physician order. Goal: Resident #309 will breathe easily and comfortably.

During an observation of Resident #309 conducted on 12/09/24 at 11:07 AM, he was observed resting in bed with Oxygen infusing at three to four (3-4) liters via Oxygen concentrator, but with no current Physician orders noted. Oxygen signage was posted outside the resident's door.

On 12/09/24 at 3:39 PM, Resident #309 was still observed resting in bed with Oxygen infusing at three to four (3-4) liters via Oxygen Concentrator, but still with no current Physician orders noted in place.

On 12/10/24 at 11:16 AM Resident #309 was observed resting in bed with Oxygen infusing at three to four (3-4) liters via Oxygen Concentrator, but was still with no current Physician orders noted in place.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER: Pearl at Fort Lauderdale Rehabilitation and Nursin		STREET ADDRESS, CITY, STATE, ZIP CODE: 1701 NE 26th St Fort Lauderdale, FL 33305	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 4:07 PM, Resident #309 was observed resting in bed with Oxygen infusing at three to four (3-4) liters via Oxygen Concentrator, but still with no current Physician orders noted in place. On 12/11/24 at 1:02 PM, Resident #309 was again observed resting in bed with Oxygen infusing at three to four (3-4) liters via Oxygen Concentrator, but still with no current Physician orders noted in place. An interview was conducted on 12/09/24 at 11:10 AM with Resident #309, who stated that he wears it [oxygen] a lot. A side-by-side record review was conducted with Staff S, Licensed Practical Nurse (LPN), in which it was noted there was no current order on record for Oxygen therapy for Resident #309. There was no documentation pertaining to Oxygen Therapy in the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). The MARs and TARs lacked evidence of documentation that the Oxygen was being initialed / signed off as having been administered to the resident. An interview was conducted with Staff S on 12/11/24 at 1:08 PM, regarding the resident receiving continuous Oxygen therapy without a physician's order. Staff S acknowledged there was no current order on file for the Oxygen and stated that she could not recall how long he had been receiving it. An interview was conducted with Staff T, LPN/Unit Manager (LPN/UM) on 12/11/24 at 2:32 PM regarding the resident receiving continuous Oxygen therapy without a physician's order. Staff T acknowledged there was no current order on file for the Oxygen. A physician's order for Oxygen was not obtained until after surveyor intervention. On 12/11/24 at 4:32 PM, the DON further recognized and acknowledged that the resident was currently receiving Oxygen therapy without a physician's order in place. 50370 2. Review of facility's policy, titled, Respiratory Medication Administration - via Small Volume Nebulizer, updated on 08/17/24, revealed that nebulization is used to deliver medications along the respiratory tract, and is indicated for various respiratory problems and diseases; The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. Statement #3 under 'Policy Interpretation and Implementation' revealed to closely monitor and document respiratory status, breath sounds (pre-and post-treatment), respiratory rate (pre-and post-treatment), and pulse rate (pre, middle, and post-treatment), and document on Flow sheet. Additional policy statements under #3 revealed the following: 3.1: Evaluate chest wall expansion, depth, and pattern of respirations, cough, and chest pain; 3.2: Watch for restlessness, which may indicate that the patient is hypoxic, requiring suctioning, repositioning, or more aggressive oxygen therapy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024

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Pearl at Fort Lauderdale Rehabilitation and Nursin	1701 NE 26th St Fort Lauderdale, FL 33305

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The same policy revealed under statement #7, to position the resident in semi-Fowler's position (head and upper body raised to a 30-45-degree angle while lying on back). Record review revealed Resident #120 was admitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbation, Acute Respiratory Failure with Hypercapnia, Atrial Fibrillation and Sleep Apnea. Review of Minimum Data Set (MDS) assessment, dated 11/20/24 at 10:23 AM, revealed a BIMS score of 14, indicating intact cognition. Record review of a nursing care plan dated 08/21/24 revealed the resident has altered respiratory status, and difficulty of breathing related to anxiety, acute hypercapnia (condition where body has too much carbon dioxide in the blood), respiratory failure, sleep apnea, emphysema (lung disease that damages air sacs, forming into large packets and trapping oxygen), and COPD. The nursing care plan additionally revealed the following goals: the resident will maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review date; the resident will have no complications related to Shortness of Breath (SOB) through the review date; and resident will breathe easily and comfortably. Further review of nursing care plan interventions, dated 08/21/24, revealed the following: assess the degree or level of anxiety, breathing treatment as ordered, and oxygen therapy per physician order. Review of Resident #120's hospital's history and physical dated 08/15/24, completed by a Medical Doctor, revealed the following: Resident #120's chief complaints include shortness of breath (resident was at nursing facility when oxygen saturation's remained low, after a breathing treatment was administered; resident was given a DuoNeb treatment in route, and came in with oxygen at 10 Liters per minute on a simple mask; resident states she is having breathing difficulty, and chest discomfort). Review of physician orders revealed the following: Ipratropium-Albuterol Solution 0.5-2.5 (3) MG (milligram)/3mL (milliliter), 3 mL inhale orally, via nebulizer, four times a day for Bronchospasm; Toleration of Treatment: G-Good ; F-Fair ; P-Poor: Document # of minutes breathing treatment was administered; Respiratory Evaluation: Breath Sound Code: 1=Clear, 2=Diminished, 3=Rhonchi, 4=Crackles, 5=Wheezing, 6=Other (Explain); Quality: A=Unlabored. Review of the Medication Administration Record (MAR) for a nebulizing treatment order, with a start date of 11/12/24 at 6:00 PM, revealed the following: Ipratropium-Albuterol solution 0.5 -2.5, (3) MG/3mL, to be inhaled orally via a nebulizer four times a day for Bronchospasm; Toleration of treatment coded as follows: G= good, F=fair, P=poor; Document the number of minutes breathing treatments was administered; Respiratory evaluation: breath sounds code as follows: 1=clear, 2=diminished, 3=rhonchi, 4=crackles, 5=wheezing, 6=other and explain; quality as follows: a=unlabored. Further review of the above MAR revealed the documented nurses' initials and check marks indicating the nebulizing treatments were administered by nurses. Review of the MAR revealed there was no information about the resident's toleration of treatments, number of minutes the breathing treatments were administered, respiratory evaluations, quality of breath sounds and other explanations while administering the nebulizing treatments from 12/01/24 until 12/07/24, and on 12/11/24 and 12/12/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER: Pearl at Fort Lauderdale Rehabilitation and Nursin		STREET ADDRESS, CITY, STATE, ZIP CODE: 1701 NE 26th St, Fort Lauderdale, FL 33305	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 12/09/24 at 10:35 AM, Resident' #120's head was about 10 to 15 degrees elevated (closer to lying flat in bed), while receiving nebulizing breathing treatment, with no staff nurse inside the resident's room. The nebulizing machine created loud noises, and after a few minutes on 12/09/24 at 10:38 AM, the resident took the breathing treatment mask off from her lower face and held it at her side. Resident #120 showed signs of breathing difficulty when Staff M, LPN came inside the room, which subsided after the nebulizer treatment. Staff M took the breathing mask from the resident, and after donning on gloves, went inside the bathroom and cleaned the mask. Staff M left the room at 10:40 AM. She did not assess Resident #120's breath sounds or take vital signs such as respiratory rates and pulses. She was observed without stethoscope upon entering resident's room. In an interview with Staff M on 12/09/24 at 10:58 AM, when asked why she was not in the room during Resident #120's nebulizing treatment, she did not respond. In an interview with Resident #120 on 12/09/24 at 4:29 PM, when asked if staff stay with her during the duration of nebulizing treatment, she stated Sometimes, staff stay for few minutes, then, would leave, and come back when the treatment is over. In an interview with Staff O, North Wing Unit Manager Registered Nurse (RNUM), on 12/11/24 at 11:10 AM, when asked about the process of providing nebulizing treatment to a resident, she stated that nurses always stay with the resident to monitor changes before and after the nebulizing treatment. She added that nurses check resident's vital signs, lung sounds, respiratory changes and resident's tolerance of the treatment. Staff O stated the nurses document the amount of time they stayed with the resident together with the amount of treatment tolerated by the resident. In an interview with the Director of Nursing (DON) on 12/11/24 at 4:00 PM, he stated facility nurses stay with residents during nebulizing treatments. He added that during a two-day orientation, nurses were educated about monitoring residents until the end of nebulizing treatments. In an interview with Staff BB, Respiratory Therapist (RT), on 12/12/24 at 1:31 PM, regarding nebulizing treatment, she stated that it is a recommended guideline that nurses stay with residents during the entire duration of nebulizing the treatments. When asked if she observed nurses leaving residents while receiving nebulizing treatments, she stated that she has been working in the facility for two weeks. When asked why staff nurses must stay with residents during nebulizing treatments, she stated that bronchospasms and difficulty of breathing might occur to residents receiving the treatments. Staff BB stated that When nurses are monitoring the residents, they (RT) are readily available to respond to residents' breathing difficulties.

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	105089	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl at Fort Lauderdale Rehabilitation and Nursin	1701 NE 26th St Fort Lauderdale, FL 33305

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interview and record review, the facility failed to follow physicians' orders for fluid restrictions for 2 of 2 sampled residents reviewed for dialysis, Resident #123 and Resident #89. The findings included: 1. Record review revealed Resident #123 was readmitted to the facility on [DATE] with a diagnosis of End-Stage Renal Disease and is dependent on dialysis. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #123 has a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. Review of the physician's orders showed an order dated 12/09/24 for fluid restrictions of 1500 milliliters (ml) a day, with 420 ml allocated for nursing and 1080 ml allocated for dietary. Further orders showed that Resident #123 was receiving dialysis three times a week in-house. In an observation conducted on 12/09/24 at 12:55 PM, Resident #123 was not in the room, and her lunch tray was noted at the bedside. The lunch tray was noted with a meal ticket that showed a Renal Dialysis diet and fluid restriction of 1140 ml a day. The lunch tray was noted to have 4 ounces of cranberry juice, 8 ounces of diet ginger ale, and 16 ounces of Styrofoam cup of water near the lunch tray. The above observation showed that Resident #123 received 28 ounces of fluids, which was about 829 ml of fluids for one meal. In an interview conducted on 12/10/24 at 7:50 AM, Resident #123 stated that she goes to dialysis three days a week in the facility. When asked if she was on fluid restrictions, she said yes and that it was around 1500 ml a day but she was not sure. Resident #123 reported that she was not educated on the fluid restrictions and how many fluids she is allowed a day. In another interview conducted on 12/10/24 at 8:50 AM, Resident #123 said that her meal ticket this morning showed that she was on 1080ml fluid restrictions and then said, I wish someone explained this to me in ounces because I do not understand ml. In this interview, Resident #123's meal ticket showed a Renal Dialysis diet with 1080 ml fluid restrictions and 8 ounces of juice. The Breakfast tray consisted of 12 ounces of coffee and 8 ounces of juice for a total of 20 ounces of fluids (640 ml). In an interview conducted on 12/12/24 at 11:47 AM, Staff Q, Certified Nursing Assistant / CNA, stated that Resident #123 was not allowed to get too many fluids but did not know how many ounces of water Resident #123 was allowed. In an interview conducted on 12/12/24 at 11:59 AM with Staff R, Registered Nurse, the nurse stated that the fluids restrictions are written in the medial chart which showed that exact number of fluids that are allocated for Dietary and the fluids allocated for Dietary. The meal ticket will also have the exact number of fluids allowed for the day. 50370 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0698

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

2. Record review revealed Resident #89 was admitted on [DATE] with diagnoses that included Acute Kidney Failure, Chronic Kidney Disease, Hyperkalemia, Fluid Overload, Chronic Metabolic Acidosis related to Secondary Hyperparathyroidism and Diabetes Mellitus.

Review of the current Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.

Review of physician orders dated 11/26/24, revealed in house-dialysis, every day shift on Monday, Wednesday, and Friday at 8:30 AM.

Review of physician orders dated 12/03/24 at 3:00 PM revealed fluid restriction: 240 ml (milliliter), (LPS (Liquid Protein Supplement) 1X [one time]), every day (AM) shift.

Additional orders dated 12/04/24 revealed a 1200 ml fluid restriction: 120 ml every evening (PM) shift, and fluid restriction: 120 mL every night shift, with a total of 1200 mL daily fluid restriction, and an allotment of 480 mL for nursing and 720 mL for dietary.

Review of facility's carbon copied document, titled, Fluid Restriction Pattern, submitted by the Registered Dietician on 12/12/24 at 12:30 PM, revealed the following: breakfast of 120 mL juice; lunch of 240 mL tea and 180 mL soup; dinner of 180 mL water. The document revealed 240 ml of Nursing provided fluids in AM shift, 120 ml during PM shift, and 120 ml at night shift.

The document included the following notations: no water pitcher and follow pattern on card; daily total of 1200 mL; distribution for Nursing of 480 mL and Dietary for 720 ml. The document was signed by a Dietician and by Staff O, Unit Manager Registered Nurse (UM/RN) on 12/03/24. Further review of this facility's document revealed blackened lines on items under AM snack, lunch, on and under shift total.

Review of Resident #89's meal tickets dated 12/09/24 until 12/14/24, provided by the Kitchen Manager on 12/12/24 at 10:00 AM, revealed no written information regarding fluid restriction.

Additional review of facility's paper, titled, Task: Fluids consumed in cubic centimeter (cc's) and percent (%), (breakfast, lunch, dinner), provided by the Director of Nursing (DON) on 12/12/24 at 2:30 PM, revealed: on 12/06/24 at 12:53 PM, Resident #89 consumed 180 ml; at 2:31 PM, 180 ml; and at 10:15 PM,120 ml, for a total of 480 ml fluids provided by Nursing staff.

Further review of the document revealed the following: On 12/07/24, Resident #89 consumed a total of 600 mL fluids; on 12/08/24, 580 ml; on 12/09/24, 360 ml; on 12/10/24, 600 ml; on 12/11/24, 720 ml; and on 12/12/24, Resident #89 consumed fluids at 10:47 AM and at 1:55 PM totaling 480 ml of fluids provided by Nursing staff.

During observation on 12/11/24 at 9:00 AM, Resident #89's breakfast meal ticket revealed the following: on top of the horizontal black line showed Resident's name, room number, North Cart 1-28, renal/chronic kidney disease-dialysis diet/CCD, date, and breakfast; below the black horizontal line showed garden scrambled eggs for 2 ounces (oz), oatmeal for 6 oz (180 mL), coffee cake for one piece, apple juice for 4 oz (120 ml), hot tea for 2 cups (480 ml), milk 2% for 4 oz (120 ml), sugar substitute for 2 pieces (pc). The total fluids on the breakfast tray provided by Dietary Services was 900 ml. There was no written information on Resident #89's meal ticket regarding fluid restriction.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105089	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl at Fort Lauderdale Rehabilitation and Nursin	1701 NE 26th St Fort Lauderdale, FL 33305

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 12/12/24 at 9:30 AM, Resident #89's meal ticket revealed the following: on top of the horizontal black line showed Resident's name, room number, North Cart 1-28, renal/chronic kidney disease-dialysis diet, day, (W3-D19), breakfast, 12/12/2024; below the black horizontal line showed turkey sausage for one oz, oatmeal for 6 oz (180 ml), cinnamon French toast for 2 each, apple juice for 4 oz (120 ml), hot tea for 2 cups (480 ml), milk 2% for 4 oz (120 ml) and sugar substitute for 2 pc. The total breakfast fluids provided by Dietary Services was 900 ml. There was no written information on Resident #89's meal ticket regarding fluid restriction. An interview was conducted with Staff FF, Certified Nursing Assistant (CNA) on 12/12/24 at 1:27 PM, who stated she has been working in the facility for one year. When asked if she documents the amount of fluid Resident #189 consumes during her AM shift, she stated she does and added that she is aware Resident #189 is on fluid restriction. When asked how much fluid Resident #89 is allowed on her shift, she stated she must check the records. When asked if she could provide the printed daily amount of liquids she documented on her CNA task, she replied, I will ask one of the nurses to print it for me. The DON provided the printed task sheet on 12/12/24 at 2:30 PM. In an interview with the Kitchen Manager on 12/12/24 at 1:57 PM, she stated the Registered Dietician (RD) tells her the names of residents on fluid restriction. When asked if she is aware Resident #89 is on fluid restriction, she stated I have to check my record. When showed the resident's meal ticket showing that fluid restriction was not written, she stated she did not know Resident #89 was on fluid restriction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49060

Based on observations, interviews, and record review, the facility failed to ensure controlled substance medication reconciliations were accurate for 4 of 12 sampled residents reviewed during the controlled substance record review, Residents #14, #168, #186, and #201.

The findings included:

Review of the facility's policy, titled, Controlled Substances, dated 11/2022, included the following:

The facility complies with all laws, regulations, and other requirement related to handling, storage, disposal, and documentation of controlled medications.

Dispensing and Reconciling Controlled Substances:

1.Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.

2.The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following:

a. Records of personnel access and usage;

b. Medication administration records;

c. Declining inventory records; and

d. Destruction, waste and return to pharmacy records.

1. Record review for Resident #14 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Acute Kidney Failure, Metabolic Encephalopathy, Generalized Anxiety Disorder, Primary Insomnia, and Chronic Obstructive Pulmonary Disease.

Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.

Review of the Physician's orders showed that Resident #14 had an order dated 12/04/24 for Alprazolam (Xanax) 1 mg tablet, give one tablet every 12 hours as needed for anxiety.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 5:28 PM, a record review of Resident #14's Controlled Drug Disposition sheet was conducted. The disposition sheet for Alprazolam (Xanax) 1 mg (30 tablets), to be given every 12 hours as needed for anxiety, was received by the facility from the pharmacy on 12/04/24, and revealed there were 23 tablets left in the controlled substance box. Further review of the disposition sheet revealed between 12/04/24 and 12/10/24, seven (7) tablets of Xanax 1mg were dispensed and removed from the controlled substance box. Review of Resident #14's December Medication Administration Record (MAR) revealed no documentation for the administration of Xanax 1mg tablet on 12/04/24 and 12/05/24 (which was documented as dispensed and removed for administration on the Controlled Drug Disposition sheet). The resident's controlled substance was not reconciled. An interview was conducted on 12/12/24 at 1:13 PM on the South-2 wing with Staff S, Licensed Practical Nurse (LPN), who stated working at the facility for [AGE] years. She stated she verifies physician's orders, dispense the controlled medication and administers to the resident. Staff S then stated after the administration, she signs both the Controlled Drug Disposition Sheet and the MAR. A side-by-side review of Resident #168 Controlled Drug Disposition sheet was conducted with Staff S and Staff T, South wing Unit Manager. Both staff were unable to explain as to why there were discrepancies in the controlled-drug administration. 2. Record review for Resident #168 revealed the resident was admitted to the facility on [DATE] and had a readmitted [DATE] with diagnoses that included: End Stage Renal Disease, Type 2 Diabetes Mellitus, Generalized Anxiety Disorder, Hereditary and Idiopathic Neuropathy. Review of Section C of the MDS assessment dated [DATE] revealed Resident #168 had a BIMS score of 15, indicating he was cognitively intact. Review of the Physician's Orders showed Resident #168 had an order dated 11/05/24 for Tramadol HCl 50 mg tablet, give 1 tablet by mouth every 6 hours as needed for pain. Review of Resident #168's Controlled Drug Disposition sheet for Tramadol HCL 50 mg (24 tablets) was received at the facility from the pharmacy on 10/11/24, and revealed Resident #168 was given the medication on the following days in November: 11/10/24 at 12:20AM and at 2021(8:21 PM), 11/11/24 at 9:40 PM, 11/13/24 at 12:30 PM and at 9:00 PM, 11/16/24 at 9:00 PM, and 11/17/24 at 8:00 PM. Further review of the Disposition sheet revealed 2 tablets of Tramadol HCL were left in the controlled substance box with the last recorded date of administration on 11/27/24 at 12:33 AM. Review of Resident #168's November MAR revealed that Tramadol 50 mg was documented with nurses' initials and times on all the above dates except for 11/13/24 at 12:30 PM, 11/13/24 at 9:00 PM and on 11/17/24 at 8:00 PM (which was documented in Resident #168's Controlled Drug Disposition sheet as dispensed and removed from the controlled substance box). The resident's controlled substance was not reconciled. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 12/12/24 at 1:13 PM on the South-2 wing with Staff S, Licensed Practical Nurse (LPN), who stated working at the facility for [AGE] years. She stated she verifies physician's orders, dispense the controlled medication and administers to the resident. Staff S then stated after the administration, she signs both the Controlled Drug Disposition Sheet and the MAR. A side-by-side review of Resident #168 Controlled Drug Disposition sheet was conducted with Staff S and Staff T, South wing Unit Manager. Both staff were unable to explain as to why there were discrepancies in the controlled-drug administration. 3. Record review for Resident #186 revealed the resident was admitted to the facility on [DATE] and had a re-admitted [DATE] with the following diagnoses: Fracture of Unspecified Part of Neck of Right Femur, Dysphagia following Cerebral Infarction, Adjustment Disorder with Depressed Mood, and Pain in Left Hip. Review of Section C of the MDS assessment dated [DATE] revealed Resident #186 had a BIMS score of 05, indicating he was severely cognitively impaired. Review of the Physician's Orders showed Resident #186 had an order dated 11/22/24 for Oxycodone w [with] / Acetaminophen [Percocet] 5-325 mg tablet, give 1 tablet by mouth every 12 hours as needed for Pain. Review of the Physician's Orders showed that Resident #186 had an order dated 12/04/24 for Oxycodone w / Acetaminophen [Percocet] 5-325 mg tablet, give 1 tablet by mouth one time a day for pain for 7 days, give prior to therapy. Hold for sedation, if Systolic Blood Pressure (SBP) <100, Respiration rate (RR) <12, Oxygen levels <92%. Review of Resident #186's Controlled Drug Disposition sheets revealed Percocet 5-325 mg (8 tablets), to be given every 12 hours as needed for Pain, was received by the facility from the pharmacy on 10/22/24, and revealed there were 4 tablets left in the controlled substance box. Further review of the disposition sheet documented that on 10/27/24, 11/30/24, 12/04/24 and 12/05/24 Percocet tablets were dispensed and removed from the controlled substance box. Review of the disposition sheet for Percocet 5-325 mg (6 tablets) to be given daily for 7 days prior to therapy, was received by the facility from the pharmacy on 12/04/24, and revealed there were 5 tablets left in the controlled substance box (one tablet was dispensed and removed from the controlled substance box on 12/09/24). Review of Resident #186's December Medication Administration Record (MAR) revealed no documentation of any administration of Percocet 5-325 mg tablet, give every 12 hours as needed for pain. Further review of the MAR revealed Resident #186 was administered Percocet 5-325 mg prior to therapy on 12/04/24, 12/05/24, 12/07/24, 12/09/24, and 12/10/24 at the scheduled time of 9:00 AM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pearl at Fort Lauderdale Rehabilitation and Nursin		STREET ADDRESS, CITY, STATE, ZIP CODE: 1701 NE 26th St Fort Lauderdale, FL 33305	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 12/12/24 at 12:37 PM with Staff U, LPN. She stated after dispensing the controlled medication, she would fill in the date, time, amount and sign the Controlled Drug Disposition sheet and initial in the MAR as well as part of the administration process. Staff U then stated, for controlled medications that are discontinued or there was a change in the orders, the requirement is for two nurses to sign the Controlled Drug Disposition sheet and the medication with the sheet are given to the Director of Nursing (DON). A side-by-side review of Resident #186's Controlled Drug Disposition sheet was conducted with Staff U. She acknowledged signing the MAR for Percocet 5-325 mg as administered on 12/07/24 and 12/10/24. Staff U was not sure why or what happened that she did not sign the Percocet's disposition sheet. 4. Record review for Resident #201 revealed the resident was admitted to the facility on [DATE] with the following diagnoses: Displaced Bimalleolar Fracture of Right Lower Leg, Primary Insomnia, and Major Depressive Disorder. Review of Section C of the MDS assessment dated [DATE] revealed Resident #201 had a BIMS score of 12, indicating she had moderate cognitive impairment. Review of the Physician's Orders showed Resident #201 had an order dated 11/19/24 for Tramadol HCl 50 mg tablet, give 1 tablet by mouth every 8 hours as needed for pain. Review of Resident #201's Controlled Drug Disposition sheet for Tramadol HCL 50 mg (5 tablets) was received at the facility from the pharmacy (date received not entered) and revealed Resident #201 was given the medication on the following days: 11/19/24 at 10:27 AM, 11/25/24 at 12:26 AM, and 12/09/24 at 11:25. Further review of the Disposition sheet revealed there were 2 tablets of Tramadol HCL left in the controlled substance box. Review of Resident #201's December MAR revealed that Tramadol 50 mg tablet was not administered on 12/09/24 (which was documented in Resident #201's Controlled Drug Disposition sheet as dispensed and removed from the controlled substance box). The resident's controlled substance was not reconciled. An interview was conducted on 12/12/24 at 1:35 PM with the Director Of Nursing (DON) and the Consultant Pharmacist. The DON stated narcotics medications are administered to the resident and then the nurse is to document almost at the same time in the Controlled Drug Disposition sheet and the MAR. The DON also stated he does audits of the medication carts randomly, but just compares the Controlled Drug Disposition sheet amount with the medication's blister packet to confirm the count. The Consultant Pharmacist stated she and her team do audit counts of the medication carts monthly. A side-by-side review of the 4 residents' Controlled Drug Disposition sheet was conducted with the DON and the Consultant Pharmacist, in which both acknowledged the nurses require more education of controlled substance documentation and reconciliation.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on record review, observations and interviews, the facility failed to ensure residents' medication regimen (psychotropic's, antipsychotic, antiplatelet and hypoglycemic medications) were monitored appropriately as evidenced of the lack of written documentation of medication side effects, medication efficacy and behavior that were being monitored for 5 of 5 sampled residents, Resident #77, #86, #167, and #145, for unnecessary medications, and for 1 of 1 sampled resident, Resident #73, reviewed for Mood / Behavior. The findings included: Review of the facility policy, titled, Pharmacy Services-Role of the Consultant Pharmacist, with a revision date of 04/2019, documented in part, .the facility shall have the services of a consultant pharmacist . collaborates on other aspects of pharmacy services, including .recommending current resources to help staff identify .medications side effects and/or adverse effects .the consultant pharmacist will provide specific activities related to medication regimen review including .appropriate communication of information to prescribes' and facility leadership about .pertinent resident-specific documentation in the medical record as indicated . 1. Review of Resident #77's clinical record documented an admission on 07/25/24 with no readmissions. The resident diagnoses included Type 2 Diabetes Mellitus, Major Depressive Disorder-Recurrent, Tobacco Use, Nicotine Dependence, Persistent Mood Disorders, Generalized Anxiety Disorder, Cognitive Communication Deficit, and Unspecified Dementia. Review of Resident #77's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented a Brief Interview of the Mental Status (BIMS) score of 14 indicating no cognition impairment. Review of Resident #77's physician orders documented the following active medications orders: *Trazodone HCl Oral Tablet 50 MG (milligrams), give 0.5 tablet by mouth one time a day for Depression Give 1/2 tablet to equal 25 mg - start dated 11/12/24. *Trazodone HCl Oral Tablet 100 MG Give 1 tablet by mouth at bedtime for Depression - start dated 11/11/24. *Cymbalta Oral Capsule Delayed Release Particles 30 MG (Duloxetine HCl) Give 2 capsule by mouth one time a day for Depression Start Date -11/02/24. *Percocet Oral Tablet 5-325 MG Give 1 tablet by mouth every 12 hours as needed for pain - start date 08/20/24. *Obtain and record accu-check blood sugar twice daily without coverage, NOTIFY MD if BS [blood sugar] less than 70 or greater than 300 two times a day for Diabetic Monitoring before breakfast and dinner. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Novolog FlexPen 100 UNIT/ML Solution pen-injector Inject 6 unit subcutaneously before meals for DM (Diabetes Mellitus) - start date 08/20/24. *Humalog KwikPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin-Lispro) Inject 6 unit subcutaneously in the evening for Hyperglycemia until Start Date -12/03/24. *Insulin Glargine -100 UNIT/ML Solution pen-injector Inject 10 unit subcutaneously at bedtime for DM-Start Date-08/20/24. *Nicotine Patch 24 Hour 7 MG\/24 HR Apply 1 patch transdermally one time a day for Smoking Cessation and remove per schedule (Active). Review of Resident #77's active care plan, titled, Resident has history smoking, initiated and updated on 11/20/24. The care plan interventions included Nicotine patch 24 hour 14 mg/24 hour one time a day for smoking cessation for two months . The care plan lacked written interventions related to monitoring of side effects of a psychotropic medication - Nicotine. Review of Resident # 77's care plan, titled, The resident uses antidepressant medication, initiated on 08/20/24, revision date 11/14/24,documented interventions to include Monitor/document side effects and effectiveness. ANTIDEPRESSANT SIDE EFFECTS: dry mouth, dry eyes, constipation, urinary retention, suicidal ideations. Monitor/document/report to MD (medical doctor) prn (as needed) ongoing s/sx (sign/symptoms) of depression unaltered by antidepressant medication: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with other, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance . Review of Resident # 77's care plan, titled, The resident has Diabetes Mellitus, initiated on 08/20/2024, revision date 11/14/24, documented interventions to include: Monitor/document/report to MD PRN (as needed) s/sx (signs and symptoms) of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait. Monitor/document/report to MD PRN for s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, coma . Review of Resident #77's clinical record lacked written evidence that care plan interventions were documented and monitored across all shifts. Review of Resident # 77's December 2024 Medication Administration Record (MAR) revealed the lack of written evidence of monitoring the resident for psychotropic medication side effects and the lack of monitoring for hypoglycemia and hyperglycemia signs and symptoms as per the resident's care plan developed on 08/20/24 and revised on 11/14/24. Review of Resident #77's, Medication Regimen Review, documented no recommendations for the reviews on 09/20/24, 10/30/24 and 11/29/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 1:54 PM, an interview was conducted with Staff DD, LPN, who stated Resident #77 continues to smoke and was getting a nicotine patch daily. Staff DD was asked how she monitors the Nicotine medication side effects and stated she did vital signs daily. Staff DD stated that she would ask the CNAs if the resident is having any problems like constipation and she would then document it on a progress note. Staff DD was asked how she would monitor the resident's psychotropics and hypoglycemic medications side effects and stated she does vital daily, monitor for pain and would ask the CNA if the resident had an any problems or side effects. A side-by-side review of Resident #77's MARs and physician orders was conducted with Staff DD who stated she did not see any monitoring of the medications side effects and verbalized that they should be monitoring according to the care plan. On 12/11/24 at 4:47 PM, an interview was conducted with the Consultant Pharmacist (CP) who was apprised of Resident #77 having a physician order for Nicotine patch and she was observed smoking on 12/10/24 late in the afternoon. The CP stated she did not know the resident was smoking and that the Nicotine patch is usually done for two months. During the interview, the CP stated that Nicotine patch was a psychotropic medication and needed to be monitored for psychotropic medication side effects and behavior. The CP agreed there was a lack of monitoring resident efficacy and needs to have behavior monitoring. The CP was asked for a GDR and stated she had not done one. A side-by-side review of Resident #77's August, September, October and December 2024's MAR was conducted with the CP, who acknowledged that Resident #77's psychotropics and hypoglycemic's medications were not monitored. On 12/12/24 at 9:25 AM, an interview was conducted with Resident #77 who stated she was trying to stop smoking but it is hard to do. The resident stated the nurses are putting on one patch and rotates the arm, did not remember if she was told for how long she was to wear the patch. The resident stated she smoked twice this week, one on yesterday evening (12/11/24) and on Tuesday. 2. Review of Resident #167's clinical record documented an admission on 04/01/24 and a readmission on 08/12/24. Review of Resident #167's clinical diagnoses documented on the face sheet included the following: Schizoaffective Disorder, Bipolar Type dated 08/12/24, Depressive Disorder-Recurrent, Schizoaffective Disorder, Bipolar Type, Generalized Anxiety, Metabolic Encephalopathy and Chronic Pain Syndrome. Review of Resident #167's active care plan documented, The resident uses anti-anxiety medications r/t (related to) Anxiety Disorder initiated on 04/22/24 with a revision on 04/22/24 with interventions that included: Monitor / document side effects and effectiveness. ANTIANXIETY SIDE EFFECTS: Drowsiness, lack of energy, Clumsiness, slow reflexes, Slurred speech, Confusion and disorientation, Depression, Dizziness, lightheadedness, Impaired thinking and judgment, Memory loss, forgetfulness, Nausea, stomach upset, Blurred or double vision. PARADOXICAL SIDE EFFECTS: Mania, Hostility and rage, Aggressive or impulsive behavior, Hallucinations- initiated on 04/22/2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #167's active care plan documented, The resident uses psychotropic medications r/t Seroquel initiated on 08/19/24 with a revision on 08/19/24 and interventions to include: Monitor/record/report to MD prn (as needed) side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS- Extrapyramidal symptoms (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person, initiated on 08/19/24. Review of Resident #167's active care plan documented, At risk for pain related to chronic pain syndrome, metabolic encephalopathy .Constipation, Chronic pain pump initiated on 04/02/24 revised on 08/19/24 with interventions to include: Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician initiated on 04/02/24. Review of Resident #167's physician orders documented the following: *10/10/24 - Lorazepam (antianxiety) Tablet 0.5 MG Give 0.5 tablet by mouth two times a day for Anxiety Give 0.5 tablet to equal 0.25 mg. *11/26/24 - Oxycodone-Acetaminophen (opioid-controlled substance) Tablet 5-325 MG Give 1 tablet by mouth every 6 hours as needed for Pain. *09/05/24 Seroquel Oral Tablet 50 MG (Quetiapine Fumarate) Give 50 mg by mouth in the evening for Schizoaffective Disorder. *10/11/24 Fentanyl Patch (opioid-controlled substance) 72 Hour 12 MCG/HR Apply 1 patch transdermally every 72 hours for pain and remove per schedule. Review of Resident #167's clinical record lacked written evidence that care plan interventions were documented and monitored across all shifts. Review of Resident #167's December 2024 MAR revealed the lack of written evidence of monitoring the resident for psychotropic, antianxiety and opioid's medication side effects as per care plans. Review of Resident #167's Medication Regimen Review, dated 10/30/24, documented under nursing recommendations, revealed, Please .ensure that .adverse effects are also being tracked .Please note that any medication used as a Psychotropic .must be tracked for specific behaviors and adverse effects . The report documented under outcome, agreed on 11/06/24. On 12/10/24 at 12:45 PM, attempted to interview Resident #167, but the resident was cursing and agitated. On 12/10/24 at 3:22 PM, a side-by-side record review and interview was conducted with the MDS Director who stated Resident #167 was initially admitted to the facility on [DATE] and had a readmission 08/12/24. The resident's quarterly MDS assessment dated [DATE] documented a BIMS 15 indicating no cognition impairment. During, the review, the MDS Director stated Resident #167 had a new diagnosis of Schizoaffective Bipolar type on 08/12/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	40153 3. Record review revealed Resident #73 was admitted on [DATE] with diagnoses of Hyperlipemia and Major Depressive Disorder. Review of the physician's order showed an order for Sertraline (depression medication) 50 milligrams one time a day, which was dated 08/09/24. Continued review of the orders did not show an order to monitor the side effects of the Sertraline. Review of the Annual Minimum Data Set (MDS) dated [DATE] revealed Resident #73 had a BIMS score of 13, indicating intact cognition. The Care Plan initiated on 05/23/24 showed that Resident #73 was on the psychotropic medication Sertraline. Interventions were in place to monitor, record, and report to the doctor side effects and adverse reactions to the psychoactive medications. In an interview conducted on 12/11/24 at 11:56 AM with the facility's Director of Nursing (DON), he stated that residents on psychotropic medications need to be monitored for behaviors and side effects. He stated that there is no order to monitor the side effects of the medication for Resident #73, and when asked if the side effects are being monitored, he said no. In an interview conducted on 12/11/24 at 12:00 PM with the Consultant Pharmacist, she stated that residents on psychotropic medications need to be monitored for side effects and behaviors. She stated that they usually write a two-part order that includes the side effects and behaviors. She said that they have not been monitoring the side effects for Resident #73. 49060 4. Record review for Resident #145 revealed the resident was admitted to the facility on [DATE] with a re-admission on 10/18/24 with the following diagnoses: Fracture of Neck of Left Femur, Type 2 Diabetes Mellitus, Major Depressive Disorder, and Primary Insomnia. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #145 had a BIMS score of 15, indicating intact cognition. Review of Section N revealed Resident #145 was on anticoagulant, opioid, antiplatelet, hypoglycemic, and anticonvulsant. Review of the physician's orders showed that Resident #145 had an order dated 11/22/24 for Trazodone HCl 50 mg tablet, to give 0.5 tablet by mouth at bedtime for Depression (Give 1/2 tablet to equal 25 mg). Further review of the physician's orders showed that Resident #145 had no orders for monitoring of behaviors and side effects for Trazodone 50 mg tablet. Review of the Quarterly Care Plan dated 11/30/24 documented that Resident #145 uses psychotropic medications (Trazodone) for Depression. The goals included: the resident will be free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation / impaction or cognitive / behavioral impairment through review date. Interventions were to: Administer medications as ordered and to monitor/document for side effects and effectiveness. Review of the September Medical Administration Record (MAR) revealed no documentation that Resident #145 was monitored for behaviors and side effects for the psychotropic medication, Trazodone. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Regimen Reviews (MRR) performed by the CP for the prior 6 months for Resident #145 reported no recommendations for monitoring of behaviors or side effects for the psychotropic medication, Trazodone. An interview was conducted on 12/11/24 at 10:50 AM with Staff Z, LPN, who stated she has worked at the facility for 2 months and has been Resident #145's nurse for 2 weeks. She stated a physician's order is needed to monitor behaviors and side effects for psychotropic medications. She acknowledged these medications require monitoring the resident's behavioral changes for all 3 (nursing) shifts. An interview was conducted on 12/11/24 at 2:27 PM with the CP, who stated side effects of psychotropic medications would be monitored by the psychiatrist and the nurses. When asked if residents on psychotropic medications should also be monitored for behaviors, she stated, yes. A side-by-side review of Resident #145's MAR and the physician's orders was conducted with the pharmacist. She acknowledged there were no behavior or side effect monitoring orders from the physician or psychologist for Resident #145 and could not believe she missed it. 50370 5. Record review revealed Resident #198 was admitted on [DATE] with diagnoses that included Type 2 Diabetes Mellitus with Foot Ulcer, Benign Prostatic Hyperplasia, Anxiety Disorder, and Atherosclerotic Heart Disease. Review of the admission Minimum Data Set (MDS) assessment revealed Resident #198 had a documented BIMS score of 13, indicating intact cognitive. Record review of the Medication Administration Record (MAR) on 12/11/24 at 2:44 PM, revealed oxycodone was administered orally on 12/01/24 for pain. The documented pain level was 10, followed by the administration of medication, but no follow up documentation regarding the effectiveness of medication as ordered by physician, had been documented. The same MAR revealed that on 12/02/24, 12/04/24,12/06/24, 12/07/24, 12/08/24 and 12/09/24, the effectiveness of the administered oral oxycodone tablets was not documented. Review of the nursing care plan interventions revealed to evaluate the effectiveness of pain interventions (frequency). Review for compliance, symptoms, dosing scheduled and resident satisfaction with results, impact on functional ability and impact on cognition. In an interview with Staff O, Unit Manager Registered Nurse (UN/RN) on 12/11/24 at 10:50 AM, when asked how the facility staff monitored residents on several medications including anti-anxiety, anti-depressant and pain medications, she responded, All the medications were monitored according to their side effects and the symptoms presented by resident. The residents were additionally monitored for pain level after the administration of medication, with their mental status and affects and their degree of sedation. In an interview conducted on 12/11/24 at 11:56 AM with the DON, he stated that residents on psychotropic medications need to be monitored for behaviors and side effects. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 12/11/24 at 12:00 PM with the CP, she stated that residents on psychotropic medications need to be monitored for side effects and behaviors. She stated that they usually write a two-part order that includes the side effects and behaviors. When asked how the facility ensures a review of medications for Gradual Dose Reduction (GDR), she responded, Psychiatry evaluation is done. In an additional interview with the facility's CP on 12/11/24 at 2:33 PM, she stated nurses should have documented the effectiveness of oxycodone oral medications on these dates (12/02/24, 12/04/24,12/06/24, 12/07/24, 12/08/24 and 12/09/24). She added that Resident #198 had experienced a lot of pain, had anxiety issues and needed to be monitored. She said that facility nurses have not been monitoring the outcomes or the effectiveness of oxycodone medication after administration to Resident #198. 51663 6. Record review revealed Resident #86 was admitted on [DATE] with diagnoses that included: Major Depressive Disorder and Seizure Disorder. The quarterly MDS assessment dated [DATE] revealed a BIMS score is 00, indicating severe cognitive impairment. A thorough review of the care plan dated 09/12/24 indicated that Resident #86 is prone to side effects related to the use of: Antipsychotic, Antidepressant, Anticoagulant, Anticonvulsant, which need to be observed for potential side effects such as: hypotension, tachycardia, nausea, vomiting, diarrhea, blurred vision, chest pain, rash, drowsiness, lethargy. Review of the physician orders, the Medication Administration Reports (MARs) and the Treatment Administration Reports (TARs) indicated the facility failed to obtain an order and implement intervention to monitor side effects related to the use of antidepressant medications for Resident #86.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on observations, interviews, and record reviews, the facility failed to store residents glucometers in a sanitary manner; failed to securely lock the North wing medication storage door, and failed to secure medications at the bedsides for 1 resident, Resident #407. The resident census at the time of survey was 196. The findings included: Review of the facility's policy and procedure, titled, Medication Labeling and Storage, provided by the Director of Nursing (DON) published 11/08/24, documented in the Policy Statement: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Statement #2 revealed the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Statement # 3 of the same policy revealed if the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 1. During observation of the North wing medication storage room on 12/11/24 at 4:40 PM, a glucometer was observed on top of the first drawer on the right side of North Wing Medication cart. The glucometer was not contained in a plastic container or wrap, and its back part was directly touching several blue sterile lancets contained in a blue plastic box. These sterile blue lancets are used for pricking residents' fingers to check blood glucose levels. In an interview with Staff N, Registered Nurse, on 12/11/24 at 4:55 PM, she stated that a glucometer must be plastic wrapped when placed on top of Assure sterile blue lancets. When asked why it was not done, she kept quiet. 2. In an observation on 12/11/24 at 5:45 PM, the North wing medication storage room door was observed to be halfway opened. A closer observation revealed there were no staff present inside the North wing medication storage room. Further observation revealed staff were in the hallways, some residents wheeling on wheelchairs, some visitors walking around, but there was no visible staff sitting at the nurse's station on the left side of North wing medication storage. The surveyor continued the observation of the door for 10 minutes, and on 12/11/24 at 5:56 PM she informed one of the staff, that the door was left open for a long time without staff supervision. The staff member from central service stated she would close it. The surveyor left the area as soon as the central service staff locked the North wing medication storage door. The North wing medication storage room key was hanging outside on the desk below and to the right of a printer at the nurses' station next to the medication storage room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER: Pearl at Fort Lauderdale Rehabilitation and Nursin		STREET ADDRESS, CITY, STATE, ZIP CODE: 1701 NE 26th St, Fort Lauderdale, FL 33305	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In another interview with the Director Of Nursing (DON) on 12/12/24 at 9:00 AM, he stated there is no facility policy for glucometer storage in the Medication cart, but he educates nurses during the 2-day orientation upon hire that glucometers are cleaned and stored, contained in a plastic bag before putting inside the medication cart. 38349 49060 3. Record review revealed Resident #407 was admitted to the facility on [DATE] with the following diagnoses: Urinary Tract Infection, Type 2 Diabetes Mellitus (DM) with Hypoglycemia Without Coma, and Adjustment Disorder with Depressed Mood. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #407 had a Brief Interview for Mental Status (BIMS) score of 15, indicating an intact cognitive response. Review of Section N revealed that Resident #407 was on a hypoglycemic medication. Review of the physician's orders showed that Resident #407 had an order dated 11/30/24 for Insulin Glargine-yfgn 100 UNIT/ML Solution pen-injector, inject 20 unit subcutaneously at bedtime for DM. During observation of Resident #407's room on 12/09/24 at 10:41 AM, it was observed that there was a (Toujeo Max SoloStar) insulin dispenser pen with an expiration date of 05/31/25 sitting on Resident #407's nightstand bedside table with her glasses. Photographic .Evidence Obtained. The insulin dispenser pen was unsecured, in plain sight and accessible to other residents, staff members and visitors. An interview was conducted on 12/09/24 at 10:41 AM with Resident #407, who stated the insulin dispenser pen belonged to her and she brought it from home. She stated she had it since admission and believes the insulin pen is empty. During a second observation conducted on 12/11/24 at 10:29 AM, Resident #407 was in bed sleeping, no insulin dispenser pen was noted on her nightstand bedside table. An interview was conducted on 12/11/24 at 11:21AM with Staff Y, Certified Nursing Assistant (CNA), who stated she has worked at the facility for about [AGE] years and 2 years on the [NAME] 2 wing. Staff Y stated she has not seen any medications in residents' rooms. She stated if there were medications in the rooms, she would remove them and give them to the floor nurse or supervisor. She acknowledged residents are not to have any medications from home in their rooms. An interview was conducted on 12/11/24 at 11:29 AM with Staff U, Licensed Practical Nurse (LPN), who stated she started working at the facility about 2 months ago and always scheduled to the [NAME] 2 wing. She stated that upon a resident's admission, the floor nurse does an assessment, and the supervisor inputs the medications into the computer. Staff U also stated that any medications the resident has brought in from home are collected by either the floor nurse or supervisor and the family is called to pick them up. Staff U stated residents and family are educated not to bring any medications from home. She stated she has not seen any medications in residents' rooms but she did recently have to educate a resident because she had medications at the bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 12/11/24 at 12:50 PM with the Director of Nursing (DON). He stated the floor nurses and unit managers are responsible for collecting any medications brought from home, then they contact the family member. The DON stated the staff have been educated to retrieve any medications brought from home. A side-by-side review of the photograph obtained from Resident #407's room of the insulin pen was conducted. The DON acknowledged that the medication was not collected, but they cannot search through the resident's belongings. The DON was reminded that Resident #407 has been in the facility since 11/29/24 and she stated she had the insulin pen since admission.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 51663 Based on observations, interviews and record reviews, the facility failed to follow their menu for the regular diet during 1 of 2 observations in the main kitchen. This has the potential to affect 117 residents on a regular diet. The census at the time of survey was 196. The findings included: Review of the fall/winter 2024 diet guide sheet provided to the surveyors included the following menu for the regular diet consistency: 4-ounces (oz) of seasoned cauliflower, 4-oz of spanish rice and 3-oz of apple butter pork loin. In an observation conducted in the main kitchen on 12/11/24 at 11:25AM, the surveyor observed that a lunch tray consisted of pieces of Apple Butter Pork Loin that were pre-sliced. The surveyor asked to put a piece of the Pork Loin on a facility's scale which showed the slice of Pork had a weight of 2.25 ounces. The piece of the Pork was not the correct weight according to the facility's menu that should have been for 3 ounces. An interview was conducted on 12/12/24 at 2:00 PM with the Food Service Director IFSD) who stated that the cook is supposed to pre-cut the slices of Pork before plating it for the lunch meal, and to weigh each slice to ensure that it is around 3 ounces each.

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F 0805

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40153

Based on observations, review and record review, the facility failed to provide food in a form designed to meet individual needs for the Pureed diet consistency for 2 of 2 sampled residents observed during dining, Resident #22 and Resident #48. This has the potential to affect 17 residents on a Pureed diet.

The findings included:

Review of the facility's policy, titled, Modified Solid/Liquid Diet Consistency Policy and Procedure, not dated, showed the following: the purpose of this policy is to promote safe swallowing and minimize the risk of aspiration of solids/liquids for patients with impaired swallowing abilities. When prepared appropriately, it allows patients to exert less effort with mastication and allows the ability to control the solids and Liquids in the mouth. This yields a more efficient and safer swallow with less risk of aspiration or choking. It further showed that for the Pureed consistency diet, the food that is allowed on this plan must be pureed, cohesive, pudding-like food in a form without particles.

1. Record review showed that Resident #22 was admitted on [DATE] with diagnoses of Cerebral Atherosclerosis and Hypertension. The admission Minimum Data Set (MDS) assessment showed a Brief Interview of Mental Status (BIMS) score of 06, indicating severe cognitive impairment.

In an observation conducted on 12/10/24 at 8:20 AM, Resident #22 was in his room eating the breakfast meal. The meal ticket was noted to have pureed breakfast meat and pureed pancakes. Closer observation revealed the pureed pancakes that were not of a smooth consistency and were noted to have lumps.

2. Record review showed that Resident #48 was admitted on [DATE] with diagnoses of Dementia and Depressive Disorder. The Quarterly MDS assessment showed that Resident #48 cognitive status was severely impaired.

In an observation conducted on 12/10/24 at 8:37 AM, Resident #48 was noted in her bed with the breakfast tray at the side table. The meal ticket showed a regular pureed diet with pureed breakfast meat, pureed fortified oatmeal, and pureed pancakes. Closer observation revealed the pureed breakfast meat and pureed pancakes were not smooth and noted to have lumps. Continued observation at 8:49 AM revealed the pureed breakfast meat and pureed pancakes were grainy in consistency with large pieces of lumps.

In an observation conducted on 12/10/24 at 12:36 PM, Resident #48 was in the room eating her lunch meal. The meal ticket was noted to have pureed cranberry-glazed turkey, pureed broccoli, and pureed mashed sweet potatoes. Closer observation showed that the pureed turkey did not have one smooth uniformed consistency and was noted to be lumpy.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 12/11/24 at 9:22 AM with Staff GG, the Speech Therapist, who stated that they follow a national standard guideline for pureed diets. For the Pureed consistency, the food items need to have a cohesive texture that is pudding-like and easy to swallow. It should have no particles or lumps and should require no chewing.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to accommodate resident allergies, intolerance, and preferences for 3 of 3 sampled residents observed during dining observation, Resident #32, Resident #100, and Resident #144. The findings included: 1. Record review revealed Resident #32 was admitted to the facility on [DATE] with diagnoses of protein-calorie malnutrition and dementia. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview of Mental Status (BIMS) score of 03, indicating severe cognitive impairment. In an observation conducted on 12/09/24 at 12:59 PM, Resident #32 was noted in the room with the lunch tray. The lunch meal ticket was noted with the following food items: regular mechanical chopped diet, pureed carrot ginger soup, juice, 1/2 cups canned fruit, coffee, and 4 ounces of Mighty shake of choice (nutritional supplement). Closer observation of the lunch tray did not show any Mighty Shake provided on this lunch tray. An interview was conducted on 12/12/24 at 3:00 PM with the Food Service Director, who stated the tray line has staff members who check to make sure that the correct food items and supplements are on the meal tray as needed for each resident. 2. Record review revealed Resident #100 was readmitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease and Anemia. The Quarterly MDS assessment showed that Resident #100 has a BIMS score of 12, iindicating moderate cognitive impairment. In an observation conducted on 12/11/24 at 8:38 AM, Resident #100 was in the room with the breakfast tray. The meal ticket was noted as having a high-calorie pudding and asked to please send chocolate. Closer observation of the breakfast tray did not show that a high-calorie pudding was provided to Resident #100. An interview was conducted on 12/12/24 at 3:00 PM with the Food Service Director, who stated the tray line has staff members who check to make sure that the correct food items and supplements are on the meal tray as needed for each resident. 38349 (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the facility policy and procedure, titled, Resident Food Preferences, provided by the Director of Nursing (DON) published 03/13/23, documented in the Policy Statement: Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent Policy Interpretation and Implementation: 1. Upon the resident's admission (or within twenty-four (24) hours after his/her admission) the dietician or nursing staff will identify a resident's food preferences. 2. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. 3. Nursing staff will document the resident's food and eating preferences in the care plan. 4. The dietician and nursing staff, assisted by the physician, will identify any nutritional issues and dietary recommendations that might be in conflict with the resident's food preferences .10. The food services department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night Resident #100 was readmitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Sepsis, Chronic Kidney Disease, Anemia, Unspecified Convulsions, Diabetes Mellitus Type II, Hypertension, Shortness of Breath. The documented Brief Interview Mental Status (BIMS) score was 12, indicating moderate impairment. Record review of the Resident #100's Care plan initiated and revised 11/22/24 indicated Focus: Nutrition: [Resident #100] is at high risk related to diagnoses: COPD, HTN,T2DM, low Basal Metabolic Index (BMI) <21, Constipation, Malnutrition, Anemia, Depression and Chronic Kidney Disease. Interventions: Provide fortified foods daily . high calorie pudding .Goal: Resident # 100 will gain at least 1-2# per month by next review date. An interview was conducted on 12/09/24 at 2:28 PM with Resident #100, who revealed he did not receive the high calorie pudding on his lunch meal tray. He emphasized to the surveyor that this bothered him that he had not gotten his meal preference during lunch. An observation was conducted on 12/09/24 at 2:29 PM of Resident #100's lunch meal tray. It was observed that he only had the following items on his lunch tray: Talapia (fish), a portion of mashed potatoes and gravy, a bowl of broth and a cup of Mandarine oranges with two (2) cups of liquids to drink. There was no high calorie pudding on his lunch meal tray. Photographic Evidence Obtained. On 10/07/24, the physician's meal order documented, Regular texture, thin liquids consistency. On 12/09/24, Resident 100's meal ticket documented, (highlighted in yellow): High calorie pudding; please send chocolate waffle when it is not on the menu .Monday Lunch 12/9 On 11/13/24, the progress note written by Staff W, Registered Dietician / Licensed Dietitian Nutritionist (RD/LDN), documented, .Continued to encourage fortified foods (i.e. high calorie pudding) daily with meals . An interview was conducted on 12/11/24 at 2:19 PM with Staff C, Certified Nursing Assistant (CNA), regarding the contents of Resident #100's lunch meal tray for 12/09/24. She acknowledged the resident's high calorie pudding preference was missing, and stated that nursing staff are also responsible to ensure the resident's preferences are honored. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 1:59 PM, an interview was conducted with the Certified Dietary Manager (CDM), regarding the contents of Resident #100's lunch meal tray for 12/09/24. She acknowledged Resident #100's high calorie pudding preference was missing, and she stated the resident was supposed to receive the High calorie pudding if it was on the menu. She tated she was not sure why the Resident #100 did not receive what was recorded on his menu. On 12/11/24 at 2:39 PM, an interview was conducted concurrently with both Staff X, Registered Dietician Nutritionist) RDN/LDN, and with Staff W, Registered Dietician/ Licensed Dietitian Nutritionist (RD/LDN) , regarding the contents of Resident #100's lunch meal tray for 12/09/24. Both acknowledged Resident #100's high calorie pudding preference was missing. They indicated the resident's preferences were not honored, according to what the menu had written on it and what the resident actually received. There was no High calorie pudding item on Resident #100's Lunch meal tray for Monday 12/09/24, as per his preference. The DON recognized and acknowledged on 12/11/24 at 2:51 PM that the resident's meal preferences should be honored.' 51663 4. Record review showed that Resident #144 was admitted on [DATE] with diagnosis of Epilepsy and Hypothyroidism. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed BIMS score was 7, indicating severe cognitive impairment. Section GG of the MDS showed that Resident #144 needed setup or cleanup assistance during dining. Residents #144's care plan indicates that the resident is on a fortified food regimen. Review of the Order Summary Report showed the following: an order dated 09/30/24 for regular diet regular texture, thin liquid consistency, fortified foods. A thorough review of Resident #144's Care Plan dated 09/29/2024 stated the following: Monitor oral intake of food and fluid and provide fortified foods (fortified cereal w [with] / breakfast-487 calories/8 grams of protein, high calorie pudding w/ lunch and dinner-140 kcal/0 g protein). In an interview conducted on 12/11/24 at 11:45 AM, the Food Director stated the fortified food of the day and the remaining of the week on the menu is fortified mashed potato. In an observation conducted on 12/11/24 at 1:51 PM, Resident #144's lunch tray and meal ticket consisted of Apple Butter Pork Loin Baked chicken, Spanish Rice, Seasoned Cauliflower, Beef Barley Soup, Pineapple Crisp High Calorie Pudding, Juice of choice Ginger Ale. Closer observation indicated that no fortified mashed potatos were served on the tray. In an observation conducted on 12/12/24 at 1:31 PM, Resident #144 tray and meal ticket consisted of Swedish Meatballs, Buttered Parslied Noodles, Italian [NAME] Beans, Split Pea Soup, Chilled Fruit Cup, Ginger Ale. Closer observation indicated that no fortified mashed potato were served on the tray.

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	105089	A. Building B. Wing	12/12/2024

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F 0809 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50895 Based on observations and an interview, the facility failed to ensure that a nourishing snack was served to residents as required when the time lapse between the dinner and the breakfast meals was greater than 14 hours. This was observed for 1 of 1 sampled resident during observations, Resident #121. It had the potential to affect 22 of 24 residents on oral diets in the wing of rooms that included rooms 201A through 212 B. The findings included: Record review revealed Resident #121 was admitted with a diagnosis of Cancer, Anemia, Orthostatic Hypotension, Thyroid Disorder, and Depression. The documented Brief Interview of Mental Status score per Minimum Data Set (MDS) assessment dated [DATE] was 12, indicating moderate cognitive impairment. A resident council meeting was held on 12/11/2024 at 02:07 PM. Fourteen residents attended. The consensus was that there are problems in the kitchen. Residents complained of difficulty in obtaining snacks that they like at the times that they want them. Resident #121 complained that the coffee in the morning is not always on time. He said that he has knocked on the door to request the coffee and then no one answers the door. When the surveyor asked if he is served coffee with his breakfast, he said yes, but the breakfast comes too late. He wants to have his coffee earlier. When asked what time breakfast is usually served, Resident #121 responded that the trays are usually delivered around 9:30 AM. Observation revealed the dinner meal was delivered to Resident #121 in his room on 12/11/24 at 5:55 PM. The next morning, the breakfast meal was delivered to Resident #121 in his room at 8:29 AM. The time lapse between the dinner and the breakfast meals was 14 hours and 34 minutes. During an interview with Resident #121 at 8:40 AM on 12/12/24, the resident was asked if he received a snack the prior evening or night and he responded No.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50895 Based on observations and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, sanitary conditions, and to ensure the prevention of foodborne illnesses for 187 of 196 residents. The findings included: 1. During tour of the Main Kitchen on 12/09/24 at 9:30 AM, and accompanied by the Dietary Manager (DM), the following was observed and noted: a. The handwashing station near the entry door had a dark substance on the grout just above the sink. DM made aware. b. There was thick, burnt-yellow colored residue approximately 8 inches long, with varying widths, on the exterior side walls of the two Vulcan ovens. c. The back left corner of the Arctic walk-in refrigerator had brown debris splattered on the tiles close to the wall and close the leg of the shelving fixture. The leg of the fixture was resting on top of a folded-up piece of white paper soiled with various colors of debris. A yellow food substance was on the floor close to the dark sticky looking substance. d. The prepared food cart in the Arctic refrigerator had individual portions of food on plates covered with plastic wrap. The shelf with the tossed salads had a sticker on it that said 12/6 to 12/7. When the DM was asked what the dates meant, the DM answered that she didn't know what the dates meant. She went to get Staff HH, whose job functions included cooking and preparing cold foods. The DM indicated that Staff HH knew when the salads were made. Staff HH said that the second date is the last date that the food can be served. e. The dry foods storage area was observed. A crumpled ball of brown paper, and a small, dark brown, solid, oblong shaped substance was observed on the tile floor under the shelf fixtures in the back right corner of the room. f. At approximately 10:10 AM, Staff H, dietary aide, was observed preparing food while his beard was not covered with a facial covering. g. The [NAME] Bay Dishwasher temperature was 170 degrees Fahrenheit (F). According to the manufacturer's instructions posted on the wall, if the temperature goes above 140 degrees, the company should be called for service. h. A double handle stock pot had dark brown residue covering the bottom exterior of the pot and on the areas surrounding the bolts that secured both handles. Photographic Evidence Obtained.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51663 Based on observations, interviews and record reviews, the facility failed to meet professional standards and ensure that Hospice documentation was readily available for 1 of 1 sampled resident reviewed for Hospice, Resident #59. The findings included: Review of the facility Agreement provided by the facility with the Hospice company and signed on 07/27/2023 documented, in part: Facility shall prepare and maintain medical records for each Hospice patient receiving services pursuant to this Agreement. The medical records shall consist of progress notes and clinical notes detailing all Inpatient Services and events. At the request of the Hospice, a copy of the patient's medical history, records and discharge summary shall be provided to the Hospice. Additionally, a review of the Integrated Plan of Care between the Skilled Nursing Facility and the [company] Hospice dated 10/16/2024 stated the following: [company] Hospice Nurse and SNF [Skilled Nursing Facility] representative or staff designee will discuss patient case at minimum of once per week, and every time a concern arises. Medications will be reconciled by [complany] Hospice Nurse at each visit. Record review showed Resident #59 was admitted on [DATE] with diagnosis of Age-related Physical Debility. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score is 6, which indicates severe cognitive impairment. Resident #59 was admitted on Hospice on 05/31/2024. Review on 12/12/24 at 10:05AM was conducted of the care plan in the Hospice book that stated a representative or staff designee will discuss patient case at minimum of once per week and every time a concern arises and also that the Medications will be reconciled by Hospice Nurse at each visit. Review of the Hospice binder showed that 10 visitations were conducted from 06/2024 to 12/2024 by the Hospice nurse. Further review did not show any of the progress notes from the Hospice nurse in the hospice binder. In an interview conducted on 12/12/24 at 10:15AM with Staff A, Registered Nurse (RN) Manager, Staff A stated that the Hospice Nurses come weekly, and the Certified Nursing Assistant (CNA) comes daily. The RN's weekly Progress Notes are sent to the Hospice company and are not kept in the facility. He acknowledged that no Hospice staff progress notes were located in the Hospice binder for Resident #59.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105089	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl at Fort Lauderdale Rehabilitation and Nursin	1701 NE 26th St Fort Lauderdale, FL 33305

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40153 Based on observations, interview and record review, the facility's Quality Assurance and Performance Improvement Activities (QAPI/QAA) failed to demonstrate that an effective plan of actions was implemented to correct identified quality deficiencies in the problem area as evidenced by repeated deficient practices for F550, Resident Rights / Exercise of Rights; F692, Nutrition / Hydration Status Maintenance; F755, Pharmacy Services / Procedures / Pharmacist / Record; F809, Frequency of Meals / Snacks at Bedtime; and F880, Infection Prevention and Control. These repeated deficient practices have the potential to affect all 196 residents residing in the facility at the time of this survey. The findings included: Review of the facility's survey history revealed the facility was cited at F550, F692, F755, F809 and F880 during the recertification survey with an exit date of 08/31/23. The repeated deficient practices was identified for F550, Resident Rights / Exercise of Rights; F692, Nutrition / Hydration Status Maintenance; F755, Pharmacy Services / Procedures / Pharmacist / Record; F809, Frequency of Meals / Snacks at Bedtime; and F880, Infection Prevention and Control. During QAPI review, there was no evidence of an effective plan for the above cited deficienies. During an interview with the facility's Administrator on 12/12/24 at 4:30 PM, the Administrator was apprised that these 5 deficiencies would be cited on this current survey. The Administrator stated he will be working to remedy this.

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NAME OF PROVIDER OR SUPPLIER: Pearl at Fort Lauderdale Rehabilitation and Nursin		STREET ADDRESS, CITY, STATE, ZIP CODE: 1701 NE 26th St, Fort Lauderdale, FL 33305	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on observations, interviews and record reviews, the facility failed to follow the Enhanced Barrier Precautions (EBP) guidelines for 4 of 4 sampled residents reviewed for EBP, Resident #26, Resident #465, Resident #139, and Resident #460; failed to ensure employees kept fingernails trimmed as per facility's policy; and failed to keep a nebulizer mask stored in a sanitary manner. The findings included: Review of the Center for Disease Control and Prevention (CDC) Enhanced-Barrier Precautions guidelines revealed, in part, the following: Everyone must clean their hands including when both entering and leaving the room; Providers and Staff must also; wear gloves and a gown for the following: high-contact care resident care activities, dressing, bathing-showering; transferring; changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care any skin opening requiring a dressing. The CDC website included: https://www.cdc.gov/long-term-carefacilities/media/pdfs/EBP :KeepResidentsSafe-Poster-508.pdf. 1. Record review revealed Resident #26 was admitted on [DATE] with diagnoses including Fracture of the Neck of Left Femur, Left Artificial Hip Joint Replacement, Coronary Atherosclerosis, Pressure Induces Deep Tissue Damage of Left Heel, and Pressure Induced Deep Tissue Damage of Right Heel. Review of Minimum Data Set (MDS) assessment, Section C, dated 12/05/24, revealed a Brief Interview for Mental Status (BIMS) score of 08, indicating moderate impaired cognition. Review of the record revealed physician orders, dated 12/10/24, were in place for the resident's wounds. Review of the nursing care plan dated 10/29/24 revealed no Enhanced Barrier Precaution guidelines were included for Resident #26's interventions. Observations revealed the resident had an EBP signage at the door. During an observation on 12/09/24 at 10:48 AM, Resident #26 pressed her call light button to inform staff to change her socks. Staff J, Certified Nursing Assistant (CNA), came into the room, and with her bare hands touched resident's socks and lower legs, went to the bedside table of Resident #26, opened the first drawer and tried to find another pair of socks. Staff M, Licensed Practical Nurse (LPN), then came in, turned off the call light switch, and reminded Staff J to put on gloves. Both Staff J and Staff M donned gloves on both hands. Staff J removed the resident's socks from her feet, and replaced them with another pair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/24 at 11:00 AM, Staff J then removed both gloves, left the room without performing hand hygiene, and went to a storage room a few doors down. She was observed touching and twitching the doorknob with her bare hands, touching and opening a plastic container of green chucks (impermeable pad for bed sheet protection). She returned to Resident #26's room without performing hand hygiene. Staff J then obtained a pair of gloves from her top scrub pocket, touched resident's curtain with a bare hand, put on the right-hand glove, touched the resident's bed control with right gloved hand and asked the resident to turn to the left, while she was donning a glove on her left hand. Staff J slid the green chucks under Resident #26's buttock, moved to the opposite side of the bed and adjusted the chucks underneath this resident. Staff J removed both gloves, did not perform hand hygiene, left Resident #26's room, and went into another resident's room at 11:07 AM. On 12/09/24 at 11:09 AM, without performing hand hygiene, Staff J put on a new pair of gloves, touched Resident #139's bed control to lower the bed and manipulated the Hoyer lift to attach Resident #139's blue pad. Shen then helped another Staff CNA in positioning another resident (Resident #139) into a wheelchair from the Hoyer lift. When the resident was sitting on the wheelchair, Staff J removed her gloves, and without performing hand hygiene, touched the Hoyer lift's stick like control, moved the Hoyer lift out of Resident #139's room, parked it 3 doors down and stated someone is going to use it. She did not clean or disinfect the parts of Hoyer lift that made contact with Resident #139. On 12/09/24 at 11:25 AM, Staff J went inside a room [ROOM NUMBER], touched the door of the room, the bathroom door and then washed her hands inside the bathroom. 2. Record review revealed Resident #465 was admitted on [DATE] with diagnoses that included Acute Kidney Failure, Chronic Kidney Disease, Essential Primary Hypertension, Peripheral Vascular Disease, Peripheral Vascular Angioplasty with Implants and Grafts, and Compression Fracture of Second Lumbar Vertebra. Review of admission MDS revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. On 12/10/24 at 5:54 PM, during observation and interview with Resident #465's roommate and spouse, they stated they just came back from a hospital [name provided] and wanted to go inside the room. Staff I, CNA, opened the door using her gloved hand, and stated she would let them in after providing care of Resident #465. Staff I was observed wearing a mask covering her nose and mouth, and had a set of blue gloves on both hands. Closer observation revealed that Resident #465 was uncovered lying flat in bed, with the bedsheet down on the bottom of the bed, and green chucks on the right side of the bed not covering the resident. An EBP sign was posted outside the room above the room number, but Staff I was not wearing a personal protective gown (PPE). When asked how long she had been working in the facility, she stated for three years. 3. Record review revealed Resident #139 was admitted on [DATE] with diagnoses that included Gastro-Esophageal Reflux Disease, without Esophagitis, Unspecified Abdominal Hernia with Obstruction, without Gangrene, Essential Primary Hypertension, and Aftercare following Joint Replacement Surgery. Review of the MDS assessment, dated 11/25/24, revealed a BIMS score of 15, indicating intact cognition. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pearl at Fort Lauderdale Rehabilitation and Nursin		STREET ADDRESS, CITY, STATE, ZIP CODE: 1701 NE 26th St Fort Lauderdale, FL 33305	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/24 at 11:07 AM, an observation was conducted of Staff J, CNA, who left a room with an EBP sign above the room number without performing hand hygiene. She was observed to put on a new pair of gloves, touched Resident #139's bed control to lower the bed, and manipulated the Hoyer lift to attach the blue pad. She then positioned Resident #139's wheelchair next to bed and tilted it when the resident was ready to be put down from Hoyer lift to the wheelchair by another Staff CNA. When the resident was sitting on the wheelchair, Staff J removed her gloves, and without hand sanitizing, touched the Hoyer lift stick like control, and moved the Hoyer lift out of Resident #139's room. She parked it 3 doors down, and stated someone is going to use it. Staff J did not clean the Hoyer lift after it was used by 2 CNAs, and made contact with Resident #139. On 12/09/24 at 11:25 AM, Staff J went towards another room, touched the door of the room, touched the bathroom door and washed her hands inside another bathroom. She did not perform any hand hygiene before entering the other room. 4. Record review revealed Resident #460 was admitted on [DATE] with diagnoses including Paroxysmal Atrial Fibrillation, Moderate Protein Calorie Malnutrition, Unspecified Convulsions, Ischemic Cardiomyopathies, Elevated [NAME] Blood Cell Count and Urinary Tract Infection. Review of physician orders dated 11/26/24 revealed: Enhanced Barriers Precautions to coccyx wound, Foley (inventor's name of a urinary catheter tubing), and peg (percutaneous and endoscopically inserted gastrostomy) tube every shift. Review of Nursing Care plan dated 11/27/24 revealed Enhanced Barrier Precautions: Wear gown and gloves during assistance with dressing, bathing, transferring, hygiene, changing linens, changing briefs & toileting, and catheter care. During observation on 12/09/24 at 12:04 PM, Resident #460 was observed lying with 30 degrees head elevation in bed. Beside her bed was a metal pole with an attached machine for tube feeding, and a plastic bag containing a plastic syringe inside. Closer observation on 12/09/24 at 3:30 PM revealed no Enhanced Barrier Precaution (EBP) signage on top of resident's room number as seen at other rooms. There were no EBP supplies at or near Resident #460's door. An EBP cart was observed parked several doors away from Resident #460's door. During an observation on 12/10/24 at 3:30 PM, Resident #460's room had no EBP sign on top of room number. During an observation on 12/11/24 at 12:00 PM, an EBP signage was observed on top of Resident # 460's room number. 50895 5. Review of the facility's policy on Respiratory Medication Administration-via Small Volume Nebulizer, updated on 08/17/2020, stated that after a nebulizing treatment is completed, all of the nebulizer equipment should be rinsed and disinfected. It specified to rinse all pieces with sterile water (not tap water, bottled water, or distilled water); and to allow all pieces to air dry on a paper towel. It also said that when the equipment is completely dry, it must be stored in a plastic bag. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Record review revealed Resident #507 was admitted to the facility on [DATE] with diagnoses that included Pelvic Fracture, Lumbar Fracture, Malignant Neoplasm of Prostate, Chronic Obstructive Pulmonary Disease, Generalized Muscle Weakness, Unspecified Protein Calorie Malnutrition, Speech and Language Deficits following Cerebrovascular disease, and Dysphagia following Cerebrovascular Disease. The BIMS score per the Minimum Data Set (BIMS) assessment dated [DATE] was 9, indicating moderate cognitive impairment.

On 12/09/24 at 12:44 PM, Resident #507 was observed coughing during an interview process. When asked if he usually coughs so much, the resident pointed to the bedside table and said that there was a breathing machine over there. The surveyor lifted a crumpled-up sheet from on top of the bedside table that covered up most of the nebulizer machine and the entire mask. The mask was resting on top of what appeared to be a double layer of thick plastic. The mask was leaning on the telephone handset.

On 12/09/24 at 1:34 PM, Resident #507 notified the surveyor that he requested a breathing treatment from the nurse about 10 min ago. The resident stood in the doorway of his room, and he coughed several times. He appeared uncomfortable. The nurse called to the resident from down the hallway and said that she would be in shortly. She requested the resident go back into his room and wait there. The surveyor waited in the hallway to observe when the nurse attended to the resident.

The nurse was observed entering Resident #507's room at 1:56 PM and provided him with the nebulizer treatment. She then exited the resident's room.

Photographic Evidence Obtained.

36057

6. Review of the Center for Disease Control (CDC) guideline, titled, Clean Hands-Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 accessed on 12/12/24 documents, Natural nails should not extend past the fingertip . Germs can live under artificial fingernails both before and after using an alcohol-based hand sanitizer and handwashing .Healthy Habits: Nail Hygiene documents .Fingernails should be kept short, and the undersides should be cleaned frequently with soap and water. Because of their length, more dirt and bacteria can gather under long nails than short nails. This can contribute to the spread of germs .

Review of the WHO GUIDELINES ON HAND HYGIENE IN HEALTH CARE 2009- accessed on 12/12/24 documents . HCWs (healthcare workers) who wear artificial nails are more likely to [NAME] Gram-negative pathogens on the fingertips than those who have natural nails, both before and after handwashing .Long, sharp fingernails, either natural or artificial, can puncture gloves easily. They may also limit HCWs' performance in hand hygiene practices .Consensus recommendations are that HCWs do not wear artificial fingernails or extenders when having direct contact with patients and natural nails should be kept short (0.5 cm long or approximately 1/4 inch long) .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 9:40 AM, medication administration observation for Resident #201 was performed by Staff U, Licensed Practical Nurse (LPN), who started to pour the following medications: Aspirin low dose EC (enteric coated) 81 mg (milligrams), Stool softener (Docusate Sodium) 100 mg, Liquid Protein 30 cc (cubic centimeters) and Juven packet Nutrition powder which she poured into 120 cc of water. Staff U was observed struggling while donning gloves on. Staff U was observed with long glitter polished fingernails, entered the reAsicent's room, performed handwashing and assisted the resident with her medications. At 9:53 AM, an interview was conducted with Staff U who stated working in the facility since October 2024, and had 22 residents assigned to her. An inquiry was made regarding her fingernails and Staff U stated she had artificial Gel polished nails about 2 inches long. Staff U added she did them yesterday (12/09/24) for her personal / family holiday picture. Staff U was asked for the facility's policy dress code and stated she was to wear blue uniform, and they did not talk about fingernails. Staff U was asked if during orientation, the facility talked about the use of artificial nails and stated she did not remember. On 12/11/24 at 9:27 AM, observation revealed Staff U inside Resident #188's room. An interview was conducted with Staff U who stated she was very busy, and she was assisting Resident #188 who wanted to go to the bathroom. Further observations revealed Staff U continue to wear artificial fingernails noted during medication administration observation conducted with her on 12/10/24. The unit nursing staff assignment board documented that Staff U was assigned Resident #188 plus 21 more residents. On 12/12/24 at 10:19 AM, observation revealed Staff U seating at the nurses station with Staff V, Registered Nurse/Unit Manager. Further observation revealed Staff U continued to wear artificial nails and had 22 residents assigned to her. 6. On /12/12/24 at 10:10 AM, an interview was conducted with Staff V, Registered Nurse/Unit Manager who stated she had been working at the facility for six (6) months. Staff V stated her role was to oversee the unit, and assist the residents with everything that pertains to resident's care. Observation revealed Staff V with long fingernails approximately 1 inch long. An inquiry was made regarding her long fingernails and stated they were supposed to be kept the nails are a reasonable length. Staff V was asked what a reasonable length meant and she did not specify exact length. Staff V stated her fingernails nails were her own nails and had acrylic gel over them. Staff V was asked how long her fingernails were and replied that she did not measure her nails and had no idea how long they were. On 12/12/24 at 1:21 PM, a joint interview was conducted with the Director of Nursing (DON) and the facility's Regional Nurse. They were asked for nursing dress code policy. The DON was asked for the role of the unit manager (UM) and stated the UM monitors the floor, monitor nurses and Certified Nursing Assistant (CNAs) to make sure the unit is running well. The DON stated that if need be the UM has to provide resident's direct care, and added the UM is the third nurse in the unit. On 12/12/24 at 2:15 PM, a side-by-side review of the facility employee handbook and an interview was conducted with the Human Resources Director. The employee handbook documented under appearance .for the safety of our Residents natural nail tips should be keep to 1/4 inch in length. Artificial nails should not be worn when having direct contact with residents The Director was apprised of nurses with longer than 1/4 natural nails and artificial nails working in the units. The Director stated the nurses know better than to wear artificial nails and they know to keep them short.