STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105277	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stuart Rehabilitation and Healthcare	1500 SE Palm Beach Rd Stuart, FL 34994

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103 Based on record review and interview, the facility failed to ensure that the MDS (Minimum Data Set) Assessment, death assessment, was completed and transmitted within 14 days after completion for 3 of 6 sampled residents, Residents #27, #37 and #59, reviewed for closed records. The findings included: During the survey, the Risk Assessment for the Minimum Data Set (MDS) assessments was triggered for MDS records being over 120 days old for Resident #27, #37 and #59. 1. Record review of Resident #27 revealed the resident was admitted to the facility on [DATE] and expired in the facility on [DATE]. A review of the resident's MDS assessment documented the latest MDS completed was the 5-day Medicare on [DATE]. There was no death / discharge MDS assessment. 2. Record review of Resident #37 revealed the resident was admitted to the facility on [DATE] and expired in the facility on [DATE]. A review of the resident's latest MDS assessment documented it was completed on [DATE]. There is no death / discharge MDS assessment. 3. Record review of Resident #59 revealed the resident was admitted to the facility on [DATE] and expired on [DATE]. A review of the resident's latest MDS asssesment documented it was completed for admission on [DATE]. There is no death / discharge MDS assessment. During an interview on [DATE] at 9:30 AM with the MDS Coordinator, she stated that they have ,d+[DATE] days to complete an assessment, but it depends on what assessment it is. The surveyor asked her to pull up the MDS assessments for Residents #27, #37 and #59. The MDS Coordinator acknowledged that she had not completed the death assessments and had missed it. She stated, I am human, what can I say.

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 32078 Based on record review and staff interview, the facility failed to implement a baseline care plan within 48 hours of admission for 2 of 17 newly admitted sampled residents, Resident #202 and Resident #71. The findings included: 1. Record review documented Resident #71 was admitted to the facility on [DATE] with diagnoses which included Parkinsonism, Obstructive and Reflux Uropathy, Alzheimer's Disease, and Dementia. A review of Resident #71's electronic health record (EHR) contained no evidence of a Baseline Care Plan completed within 48 hours of Resident #71's admission. 2. Record review documented Resident #202 was admitted to the facility on [DATE] with diagnoses that included Dementia, Frontotemporal neurocognitive Disorder, and Anxiety. A review of Resident #202's EHR contained no evidence of a Baseline Care Plan completed within 48 hours of Resident #71's admission. On 05/22/24 at 1:50 PM, the Director of Nursing (DON) was asked where the Baseline Care Plans could be found within the electronic health records. She stated that the Baseline Care Plans are scanned into the resident's electronic record under the Observation section of the record. The DON looked with the surveyor through the EHR for Resident #202 baseline care plan. She acknowledged that the Baseline Care Plan was not in the resident's file. On 05/23/24 at approximately 1:30 PM, the DON was notified that the Baseline Care Plan for Resident #71 was also missing from the Observation section of the resident's EHR and could not be found in any other section of the EHR that was made available to the surveyor for review. The DON acknowledged that the Baseline Care Plan was not in the Resident #71's electronic file.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103 Based on record review and interview, the facility failed to ensure residents were invited to participate in care plan meetings for 1 of 19 sampled residents reviewed, Resident #61. The findings included: On 05/20/24 at 12:50 PM, and interview was conducted with Resident #61, The resident was asked if she attends her care plan meetings. She stated she didn't know what I was talking about and had never been to a care plan meeting. Review of Resident #61's medical records revealed the resident was admitted to the facility on [DATE]. A review of her quarterly MDS (Minimum Data Set) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating an intact cognition. A review of the resident's Care Plan meetings document showed the facility has had a care plan meeting every 3 months. The document showed who attended the care plan meetings that included the resident's son attending the care plan meetings via telephone. There is only one date of 07/27/23, when the resident attended. The following dates documented care plan meetings were held but did not have the resident in attendance and did not give a reason why the resident did not attend: 04/15/24, 01/17/24, 10/19/24, 05/10/23, and 02/21/23. During an interview on 05/23/24 at 9:52 AM with the Director of Social Service, the surveyor asked if Resident #61 attends the care plan meetings. He stated, 'it was established to call the son to give him updates, we just ask her how she is doing.' The Director of Social Service stated he has worked for the facility for almost a year, and it has always been established to call the son. When the surveyor asked if they invited the resident to the care plan meetings, he did not have an answer. He just kept saying it was established to have the son called. During an interview on 05/23/24 at 10:00 AM with the DON (Director of Nursing), she stated that the resident's son is involved in her care plan meetings. The surveyor asked why she was not invited, and the DON stated that she wouldn't want to go, if she saw a group of people she would get upset and think she did something wrong. She said we can talk to her in her room. The DON stated, 'I talk to her every day, and she is aware of her care.' The surveyor stated there is no documentation stating that she had talked to or invited Resident #61 to the Care Plan meetings. During a follow-up interview on 05/23/24 at 10:30 AM with Resident #61, she was advised that her son has been attending the care plan meetings by telephone. She was asked if she wanted to attend and stated, he can just do it but then stated she 'wants to go to the care plan meetings'.

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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** 25404 Based on observation, record review, interview, and policy review, the facility failed to ensure respiratory care and services for 3 of 3 sampled residents, as evidenced by staff failed to store and change oxygen and nebulizer (a device for administering a medication by spraying a fine mist) tubing for Resident #36; failed to remain with Resident #36 during a nebulizer treatment, then failed to complete a post treatment assessment as per policy; failed to assess Resident #306 before and after a nebulizer treatment; and failed to obtain a physician order for oxygen use for Resident #9. The findings included: Review of the policy, titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised October 2010, documented, in part, the process for preparing and setting up the nebulizer for administration of a medication, followed by, . 6. Obtain baseline pulse, respiratory rate and lung sounds. 17. Remain with the resident for the treatment. 26. Obtain post-treatment pulse, respiratory rate and lung sounds. This policy then described the process for cleaning followed by, 29. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. 30. Change equipment and tubing every seven days, or according to facility protocol. Documentation: The following information should be recorded in the resident's medical record. 5. Pulse, respiratory rate and lung sounds before and after the treatment. 6. Pulse during treatment. 7 Amount and characteristics of sputum production. 8. The resident's tolerance of the treatment. 9. Any adverse effects of the medication and/or treatment and physician notification, if applicable. Reporting: . 3. Notify the Physician if the resident experiences adverse effects from the medication. Review of the policy, titled, Medication Orders, revised November 2014, documented, in part, . Supervision by a Physician . 2. A current list of orders must be maintained in the clinical record of each resident. Recording Orders: . 3. Oxygen Orders - When recording orders for oxygen, specify the rate of flow, route and rationale. 1. Review of the record revealed Resident #36 was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score was not completed as the resident was rarely or never understood. This MDS documented the resident received oxygen therapy. Review of the current care plan initiated on 10/25/18 documented Resident #36 had a diagnosis of COPD and staff were to give oxygen therapy as ordered by the physician. Further review of the record revealed an order dated 11/18/19 for staff to change the oxygen and nebulizer tubing every week on Wednesdays. Another order dated 01/19/24 documented the resident was to receive oxygen at 2 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current Medication Administration Record (MAR) for May 2024 revealed Resident #36 received DuoNeb (a respiratory medication) via the nebulizer twice daily, and received Pulmicort (another respiratory medication) twice daily. Both of these medications revealed documentation on the MAR that the treatments were for 15 minutes. The documentation lacked any type of assessment, tolerance, or effects. During an observation on 05/20/24 at 11:25 AM, Resident #36 was in bed wearing a nasal cannula for the administration of oxygen, but the nasal cannula was on top of the resident's nose instead of in the nares. The tubing on the oxygen had a label dated 5/8 (Photographic Evidence Obtained). A nebulizer was noted on top of the bedside table with the tubing going into a nearly closed drawer. On 05/20/24 at 1:55 PM, while passing by the nurse's station on the way to Resident #36's room, Staff A, Registered Nurse (RN), was noted sitting at the desk and working on the computer. Upon entering the room of Resident #36, the nebulizer was noted to be running and Resident #36 was receiving a nebulizer treatment through a respiratory mask. At 2:00 PM, Staff A, RN, entered the room and took the mask off of Resident #36. The RN started to put the nebulizer mask back into the drawer, and then stated he would change it because there was no bag to store the mask. An observation of the mask revealed it was soiled with light tan spots inside the mask and the tubing lacked any date. The RN failed to do any type of post treatment assessment. A subsequent observation on 05/20/24 at 2:03 PM revealed Resident #36 wearing the oxygen and the tubing on the oxygen concentrator was still dated 05/08/24. An observation on 05/21/24 at 1:59 PM revealed the oxygen tubing on the concentrator was still dated 05/08/24, and the nebulizer mask was now in a storage bag on top of the bedside nightstand, but it was not dated. Resident #36 was in bed, the oxygen concentrator was running, and the nasal cannula was on her left cheek instead of in her nares. On 05/22/24 in the afternoon, the photograph of oxygen tubing dated 05/08/24 was shown to the Director of Nursing (DON), and the observations with Staff A were shared with the DON. The DON agreed with the concerns. 39167 2. Record review revealed Resident #306 was admitted to the facility on [DATE], with diagnoses that included Cardiorespiratory Conditions, Heart Failure, Pneumonia, and COPD. Review of the Physician order dated 05/22/24, documented for ipratropium-albuterol 0.5 mg-3 mg (2.5 mg base)/3 mL special instruction Listen to lung sounds before and after treatment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 beginning at 8:49 AM, observation of medication administration was conducted with Staff G, Registered Nurse (RN). Before the process of the nebulizer treatment (of Ipratropium-albuterol), Staff G failed to listen to Resident #306's lung sounds. After the treatment, Resident #306 removed the nasal canula (oxygen tubing) from her nose. Subsequently, she began to experience desaturation (low blood oxygen concentration). The pulse oximeter read, 60, which is considered low. Normal pulse oximeter is between 95% and 100%. After the treatment, Staff G stayed with Resident #306 for about 5-8 minutes, and instructed her to take deep breaths, purse lip breathing and kept checking the pulse oximeter, gradually the pulse oximeter was increasing, and eventually went up to 94%. Staff G failed to listen to Resident #306's lungs after completing the treatment. Staff G left the room, went to the medication cart, said he was done and proceeded to withdraw medications for other residents. On 05/22/24, at 9:20 AM, the surveyor asked Staff G if he should have listened to Resident #306's lungs sounds. especially since Resident #306 experienced de-saturation. Staff G voiced that's a good idea, but it didn't come up as an order for him to check her lungs sounds. He then asked the Assistant Director of Nursing (ADON) who was standing near them, about listening to lungs sound before and after treatment. The ADON asked him to look in the policy as she did not remember offhand. Staff G, ADON and the 500-unit Manager looked up the policy. They revealed that lungs should have been listened to before and after the treatment. During this time, the surveyor asked to see the nebulizer treatment policy and procedure. They immediately provided it. The policy, titled, administering medications through a small volume handheld nebulizer, dated October 2010, indicated that the purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. The steps in the procedures included, #6 obtain baseline pulse, respiratory rate and lungs sounds. #26 obtain post-treatment pulse, respiratory rate, and lung sounds. 33103 3. Record review revealed Resident #9 admitted to the facility on [DATE], with diagnosis that included Chronic Obstructive Pulmonary Disease (COPD), Muscle Weakness, Insomnia, Atrial Fibrillation, Severe Protein Calorie Malnutrition, Hypertension, Major Depressive Disorder, Transient Ischemic Attack (TIA), and Chronic Pain Syndrome. Review of quarterly MDS assessment dated [DATE] documented the resident has a BIMS score of 15, indicating the resident was cognitively intact. Section O documented the resident was receiving oxygen. A review of Resident #9's physician orders revealed no order in place for oxygen. Observations on 05/20/24 to 05/22/24 revealed the resident to be wearing an oxygen nasal cannula in her nose running at 2.5 liters per minute. During an interview on 05/22/24 at 9:52 AM with Staff F, Registered Nurse (RN), she was asked if resident is on oxygen, she stated yes. The surveyor asked if the nurse would look up Resident #9's physician order for oxygen. The nurse looked in the record and stated that she did not see an order. She then went back to discharge orders from 01/01/24-05/22/24, and stated the resident had an oxygen order on 03/07/24 but it was discontinued when she was sent to hospital on 03/25/24. She stated the oxygen order was not put in place when she came back on 03/27/24. She stated she uses the oxygen as needed (PRN). The nurse then went into the resident's room and took her O2 saturation, which was 96%. She took the oxygen off the resident and told her she didn't need it. The nurse said she would call the physician to get an order for oxygen as needed.

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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. 25404 Based on observation, record review, interview, and policy review, the facility failed to ensure accurate labeling of medications for 2 of 8 sampled residents, Resident #5 and #9, who had medication ordered for bedtime, with a change in scheduled administration time, and failed to identify the change on the medication packaging. The findings included: Review of the policy, titled, Medication Ordering and Receiving from Pharmacy, dated May 2022 documented, in part, Policy: Medication are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy / registered pharmacist can modify, change, or attach prescription labels. Procedures: . G. Medication labels are not altered, modified, or marked in any way by nursing personnel. 1) If the physician's directions for use change or the label is inaccurate, the nurse may place a change of order - check chart label on the container indicating there is a change in directions for use, taking care not to cover important label information. 2) When such a label appears on the container, the medication nurse checks the resident's medication administration record (MAR) or the physician's order for current information. 3) Old order is discontinued and a new order is sent to the dispensing pharmacy. 1. A medication administration observation for Resident #5 was made on 05/22/24 beginning at 4:11 PM with Staff C, Registered Nurse (RN). The RN pulled the bubble pack (medication card containing individual doses of a medication) for Atorvastatin 10 mg (milligrams) and popped a pill into the medication cup. Review of the label documented the medication was to be administered at bedtime, with no change of order sticker. Photographic Evidence Obtained. The facility's scheduled time for bedtime medications was 9:00 PM. This label also documented the bubble pack contained 30 pills and was dispensed on 05/04/24. Review of the physician's orders revealed the Atorvastatin was originally ordered on 03/24/20 to be given at bedtime and was scheduled for 9:00 PM. Review of the April 2024 MAR documented the medication was administered at 5:00 PM daily. Review of the May 2024 MAR documented the Atorvastatin was administered at 5:00 PM daily. The nursing staff failed to utilize the change direction sticker and failed to discontinue the previous order to administer at bedtime and or send the new order to the pharmacy for the administration at 5:00 PM. 2. A medication administration observation for Resident #9 was made on 05/22/24 beginning at 4:30 PM with Staff D, Licensed Practical Nurse (LPN). The LPN pulled the bubble pack for amitriptyline, an anti-depressant, and stated, Why is this coming up now at 5 (on the electronic medication administration record) when it's an HS (bedtime) medication. An observation of the label revealed the medication was to be administered at bedtime, with no change of order sticker. Photographic Evidence Obtained. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders revealed the amitriptyline was originally ordered on 11/03/23 to be administered at bedtime and was scheduled for 9:00 PM. Review of the April 2024 MAR documented the medication was administered at 9:00 PM. Review of the May 2024 MAR revealed the medication was administered at 9:00 PM until 05/11/24, when staff began administering the medication at 5:00 PM. During an interview on 05/22/24 at approximately 5 PM, a side-by-side review of the record and observation of the medication labels, the Director of Nursing (DON) agreed the labels documented the medication was to be administered at HS, yet the medications had been given during the evening at 5:00 PM. The DON explained that it was changed as per the resident's choice, and stated the Change Direction labels are on each medication cart and should be utilized for clarity.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33103 Based on record review and interview, the facility failed to document when showers or bed baths were provided for 3 of 3 sampled residents, Resident #49, #252 and #61. This has the potential to affect all residents related to system documentation. The census at the time of survey was 108. The findings Included: Review of the Policy and Procedure for shower/tub baths documented, in part, under Documentation, the following: The following information should be recorded on the resident's ADL [Activities of Daily Living] record and/or in the resident's medical record: 1. The date and time of the shower/tub was performed 2. The name and title of the individual who assisted the resident with the shower/tub bath 3. All assessment data (e.g. any reddened areas, sores, etc on the resident's skin) obtained during the shower/tub bath 4. How the resident tolerate3d the shower/tub bath 5. If the resident refused the shower/tub bath, the reason why the intervention taken 6. The signature and title of the person recording the data. Under Reporting: 1. Notify the supervisor if the resident refuses the shower/tub bath 2. Notify the physician of any skin areas that may need to be treated 3. Report other information in accordance with facility policy and professional standards of practice. 1. Review of Resident #61's medical records revealed Resident #61 was admitted to the facility on [DATE]. The resident's diagnosis included Intervertebral Disc Degeneration, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Chronic Kidney Disease, Osteoporosis, Osteoarthritis, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease: Unspecified Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety Disorder, and Hypertension. Review of the Physician Order documented, showers 3 times a week on Monday, Wednesday, and Friday on the 7:00 AM-3:00 PM shift. Review of the shower schedule showed days of Tuesday, Thursday, and Saturday on the 3-11 shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan documented, requires staff assistance for bathing. Review of the quarterly MDS (Minimum Data Set) assessment dated [DATE] documented a BIMS (Brief Interview for Mental Status) of 15, indicating cognition is intact. During an interview on 05/20/24 at 12:37 PM, Resident #61 was asked if she gets showers as per her schedule. She stated, I do not get showers except once a week. Supposed to get them Tuesday, Thursday, and Saturday. She stated she has not told them or asked them for showers but feels that she shouldn't have to. She stated that they just walk by her room and do not say anything to her. During an interview on 05/23/24 at 10:30 AM with Resident #61, she was asked if she got a shower this week. She stated no, but the RN [Registered Nurse] stated to her she did get one on Tuesday by [name]. She stated, unfortunately, cannot show evidence of it, as the state is in the building, we were flustered and didn't get stuff done. The resident stated she didn't get one but then stated she doesn't know when her last shower was. 2. Review of Resident #49's medical records revealed Resident #49 was admitted to the facility 03/12/20. The resident's diagnosis included Dissection of Abdominal Aorta; Rheumatoid Arthritis; Cachexia, Moderate Protein-Calorie Malnutrition, Mild Cognitive Impairment; Dysphagia, Idiopathic Scoliosis, and Glaucoma. Review of the physician's order documented the resident's shower days are Tuesday, Thursday, and Saturday on the 3:00 PM-11:00 PM shift. Review of the care plan documented the resident requires one to two staff assistance with bathing / showering. Review of the resident's quarterly MDS dated [DATE] documented the resident's BIMS score is a 14, indicating cognition is intact. Review of the document called Point Care History documented that showers are given 3 times a week on Monday, Wednesday, and Friday. This was the resident's old schedule when she was in a different room. The document had a date, time, shift and whether it was done and who did it. Under the date, it documented multiple days of having showers two to three times, and the word 'done'. During an interview on 05/20/24 at 1:19 PM, Resident #49 was asked if she gets her showers as scheduled. She stated she is not getting showers because it is hard for her to stand up. The surveyor asked if she wanted them, and she said yes but she didn't know her shower days. During an observation and interview on 05/23/24 at 10:45 AM, Resident #49 was still observed in a hospital gown. She stated she has been asking to get dressed since 8:00 AM and she wants a shower, Staff J, Certified Nursing Assistant (CNA) walked by and was asked to come into room. She asked the resident about a shower. Resident #49 told the CNA that she wanted a shower this morning even though her schedule is this afternoon. The CNA told her that she is getting ready to give another resident a shower but will give her a shower when she gets done. The surveyor went back into room on 05/23/24 at 12:30 PM, and the resident was asked if she received a shower. She was so excited and stated, it was [NAME]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #252's medical records revealed Resident #252 was admitted to the facility on [DATE] with a diagnosis to include Diverticulum of Esophagus: Spondylolisthesis, Cardiomyopathy, Hypertension, Subluxation of C2/C3 [cervical] and C7/T1 [thoracic], Epilepsy and Hospice Care. A review of the physician's order documents shows his shower days are 3 times a week on Monday, Wednesday, and Fridays on the 7:00 AM-3:00 PM shift. The resident's care plan documents need staff assistance with bathing. His admission MDS dated [DATE] documents he has a BIMS of 8. His cognition is moderately impaired. During an interview on 05/20/24 at 12:55 PM with Resident #252, the resident was asked if he gets showers per his schedule. He stated he has asked for showers, but they don't give them. He has no idea when his showers are scheduled. During an interview on 05/22/24 at 9:48 AM with Staff H, CNA, she was asked about the shower schedule for Resident #252 and how they document it. She took the surveyor to the computer and stated that we click on the section that shows tub/shower and clicks what the care needs are. It does not have a section for bed bath. On 05/22/24 at 10:12 AM, with the DON (Director of Nursing), she stated the Point of Care documentation is not correct. She was asked about shower schedule. She stated that the residents do not get showers every day and multiple times in a day. When we went to section GG in the MDS system and went from [NAME] to Keys, the documentation changed. She stated that they have shower sheets that are supposed to get filled out. The RN puts the name and room number on the document and the CNAs will fill it out after a shower. It is then given back to the nurse to review to see if there are any skin issues. It then gets put in a box for the DON to review and given to the wound care nurse. The problem is after the wound care nurse reviews them and when she is done, she put them in the shred box. She acknowledged that they do not have any documentation of when residents had a bed bath versus a shower.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105277	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stuart Rehabilitation and Healthcare	1500 SE Palm Beach Rd Stuart, FL 34994

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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 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** 25404 Based on observation, record review, interview, and policy review, staff failed to wear Personal Protective Equipment (PPE) during direct care for 1 of 1 sampled resident who was on Enhanced Barrier Precautions (EBPs), as evidenced by Resident #21 had an indwelling urinary catheter and Staff E, Certified Nursing Assistant (CNA), provided care and failed to don PPE. The facility also failed to ensure hand hygiene between residents during two observed meals on 1 of 4 units (100 Unit), that affected Residents #62, #5, and #35. The findings included: Review of the policy, titled, MDRO'S [multidrug-resistant organisms] and Enhanced Barrier Precautions [EBP], (not dated), documented, in part: Enhanced Barrier Precautions require the use of gowns and gloves only for high-contact resident care activities (unless otherwise indicated as part of Standard Precautions). With EBP, the use of PPE is expanded for everyone's protection. Staff are required to use gowns and gloves during high-contact resident care activities that might result in the transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident to resident during these high-contact activities, such as: dressing, bathing and showering; transferring; providing hygiene; changing linens; changing briefs or assisting with toileting; device care or use: central line, IUC [indwelling urinary catheter], feeding tube, tracheostomy / ventilator; and wound care: any skin opening requiring a dressing. 1. Review of the record revealed Resident #21 was admitted to the facility on [DATE] with an indwelling urinary catheter. Review of the current care plan initiated on 04/01/24 documented Resident #21 was placed on Enhanced Barrier Precautions (EBP) due to the use of an indwelling urinary catheter, to minimize the risk of MDRO infections. An approach included the use of PPE during high contact care such as dressing, bathing and showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and device care. An observation of personal care, to include indwelling urinary catheter care for Resident #21, was made on 05/23/24 beginning at 9:07 AM with Staff E, Certified Nursing Assistant (CNA). The CNA obtained water in a basin and set up her supplies. The CNA opened the drawer containing the gowns worn as PPE, while stating she was looking for lotion, but did not obtain or don a gown. The CNA began to assist Resident #21 with bathing, handing the resident washcloths and towel for her face and torso, leaning against the resident's bed during care. The CNA proceeded to provide personal care and care for the indwelling urinary catheter. During the bath and care, the CNA failed to don a gown. During an interview outside of the resident's room shortly after the provision of care, when asked what the purpose of the EBP or Enhanced Barrier Precautions was, Staff E did not understand the terminology. While pointing to the EBP sign at the door and asking why the sign was there, Staff E stated, So we put on gowns. The CNA went back into the room and showed the surveyor the drawer with gowns. When asked when she should put on the gown and or why she would put on a gown, the CNA could not answer. During a side-by-side review of the EBP sign, the CNA stated she understood. When asked why she did not put on a gown during the care for Resident #21, Staff E stated, Because it's new to me. (continued on next page)

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	105277	A. Building B. Wing	05/23/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An observation of the 100 Unit lunch meal was made on 05/20/24 beginning at 11:57 AM. Staff I, Personal Care Assistant (PCA), went into a resident room, and set up the resident's meal tray. The PCA then went into the common area and moved a resident in her wheelchair from the dining room, was going to take her to the main dining room, but was told she would eat on the unit so wheeled her back to the table. The PCA did not perform hand hygiene. Staff I went back to the food cart and obtained the lunch for Resident #62, and delivered it to the resident. The PCA touched the resident's bed and adjusted it, moved the pillows, repositioned the resident, removed the stuffed animals, and set up Resident #62's food. The PCA did not perform any hand hygiene, but returned to the food cart and delivered a lunch tray to Resident #5. While in the room of Resident #5, the PCA touched her face, gave the resident her drink, went back to the food cart, touching it, then went into the nourishment room to get a cup of ice chips for Resident #5. Upon return to the room, the PCA poured a drink into the cup for Resident #5, then went to the resident's dresser and pulled out clean clothing and placed it on top of the dresser. The PCA then returned to the common area and was done with the lunch delivery but failed to perform hand hygiene at any time. 3. A second meal observation was made on 05/21/24 beginning at 8:13 AM. Staff I, PCA, went into a resident room, moved the over the bed table, set up a breakfast tray, and adjusted the bed. The PCA did not perform hand hygiene, but went to the clean linen cart to obtain a clothing protector and returned it to the resident. The PCA then went to the food cart and obtained a breakfast tray for Resident #35, moving the over-the-bed table and setting up the food. The PCA returned to the food cart placing the tray on top of the cart, then went to the nourishment room for a straw, grabbed the tray back at the cart, and delivered it to Resident #5. Staff I moved the resident's table, opened the blinds, and then left to assist another staff member with positioning of another resident. The PCA failed to perform hand hygiene between residents while assisting with the delivery of food trays.