STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105410	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port St Lucie Rehabilitation and Healthcare	7300 Oleander Ave Port Saint Lucie, FL 34952

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interview, record and policy review, the facility failed to follow through with request for pain medication for 1 of 3 sampled residents reviewed for pain management, Resident #51. The findings included: Review of the facility's policy, titled, Controlled Drug Management, effective December 2020, documented, in part, Controlled substance drugs may be ordered from the Pharmacy, a script must be sent to the pharmacy. The physician may call in a controlled substance to the pharmacy. After the pharmacy has the script or the order from the physician, they may provide a code to the nurse which will allow him/her to remove the controlled substance from the emergency narcotic kit if the medication is available in the kit. Nurses will enter in the log the number of pills removed and the approval pharmacy code provided. Narcotics will be filled by the pharmacy as soon as all required elements are provided and delivered to the facility on the next scheduled delivery. Record review revealed Resident #51 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The resident's diagnoses included, Chronic Obstructive Pulmonary Disease, unspecified, Chronic pain syndrome, Primary Osteoarthritis, right hand and left hand, and Generalized anxiety disorder. Review of the quarterly Minimum Data Assessment (MDS) assessment, with an assessment reference date of 09/28/24, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Review of the resident's pain care plan dated 01/31/24 revealed a problem of: Resident reports pain related to overall condition. Has diagnosis (dx) of Chronic pain syndrome. Goal: Resident's comfort will be maximized as evidenced by decreased verbal expressions of pain thru next review date. Approach: Medications as ordered, observe for effectiveness and side effects, Notify Medical Doctor (MD) if interventions are unsuccessful or if current compliant is significant change from resident past experience with pain. An interview was conducted with Resident #51 on 09/18/24 at 10:00 AM. The resident stated she went to the emergency room last evening because she had pain in her neck and the facility had not given her the pain medication that helped in 2 days. She stated she was told it was not available. (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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/18/24 at 10:35 AM, an interview was conducted with Staff E, Licensed Practical Nurse (LPN). She confirmed that the resident did not currently have Norco available. Norco (hydrocodone-acetaminophen 5-325 milligrams (mg) is a pain medication that contains an opioid that is used to manage severe pain when other non-opioid pain medications do not treat pain well enough. Staff E stated Resident #51's primary physician is on vacation and her nurse practitioner could only write a prescription for 7 days which ran out this weekend. Staff E stated the resident went to the hospital last evening due to the pain and the hospital sent the prescription for Norco to the wrong pharmacy so they still do not have the medication. Review of the Nursing note dated 09/15/24 at 7:34 AM revealed, Contacted pharmacy to refill Hydrocodone prescription. Representative states a new prescription is needed. Information passed in shift report. Review of the Nursing note dated 09/16/24 at 8:17 PM revealed, Resident continues to offer complaints of head/neck pain. Review of the Nursing note dated 09/17/24 at 6:38 PM revealed, Resident has been complaining of pain 12/10 pain level throughout the day. Resident has been without medication for 2 days and I was unable to get a new prescription for resident. Resident decided she would like to be sent out due to the pain. Review of the Nursing note dated 09/17/24 at 11:30 PM revealed, Resident returned from (Name provided) Hospital with a prescription for Oxycodone 5 mg by mouth (po) every (Q) 6 hours/as needed (PRN) x 3 days. Resident was given morphine 4mg at the hospital and her pain scale (P/S) was at 3 upon admission. Review of the Nursing note dated 09/18/24 at 11:05 AM revealed, The resident was seen by (pain management) due to chronic pain. The resident was open to meeting with [pain management] for this consultation. The pain management nurse practitioner discontinued the Oxycodone prescription from the hospital and ordered Hydro/APAP (Norco) 5-325 mg Q 8 hr PRN. Review of the emergency room discharge instructions dated 09/17/24 revealed the resident was seen for acute exacerbation of chronic low back pain and acute exacerbation of chronic leg pain. Review of the pain medications on the September 2024 Medication Administration Record (MAR) revealed: Hydrocodone-acetaminophen 5-325 mg 1 tablet every 8 hours PRN for moderate to severe pain. Lidocaine 4% patch topical, apply to left hand once a day for pain. Meloxicam 7.5 mg once a day for pain unspecified. Tramadol 50 mg 1 tablet every 6 hours PRN for chronic pain syndrome . (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Voltaren Arthritis pain gel twice a day give one gram on left wrist twice a day for acute pain. Ibuprofen 200mg 3 tabs three times a day every 8 hours as needed for pain. Ketorlac 10 mg 1 tablet every 6 hours as needed for pain. Review of the MAR for Resident #51 for 09/12/24 - 09/15/24 revealed she was given the following: On 09/12/24 at 6:27 AM, Norco for a pain level of 6; On 09/12/24 at 2:04 PM, Norco for a pain level of 7; and On 09/12/24 at 8:07 PM, Norco for a pain level of 7. On 09/13/24, she was given Norco as follows: At 9:20 AM for a pain level of 9, At 8:05 PM for a pain level of 5. On 09/14/24, she was given Norco at 1:53 PM for a pain level of 8 and 9:10 PM for a pain level that was not indicated on the MAR. On 09/15/24, she was given Norco at 10:24 AM for a pain level of 8. There was no more Norco left after this dose. On 09/18/24, the surveyor was presented with a signed statement from 09/16/24 from Resident #51 that she was offered Tylenol/Ibuprofen and declined - I wanted hydrocodone. An interview was conducted with the Director of Nursing (DON) on 09/18/24 at 1:07 PM. The pharmacy sent a 72 hour supply of Norco because the prescription did not specify for non acute pain. She used up the 72 hour supply. The last dose was 09/15/24 at 10:24 AM. An interview was conducted with the Consultant Pharmacist on 09/19/24 at 12:15 PM, who stated the facility could not have used Norco from the emergency kit (e-kit) Controlled Narcotic box because they did not have a current prescription. The facility would have had to obtain a new prescription for Norco, then it would be sent to the pharmacy, then the pharmacist would be able to give them a code to open the e-kit. The Norco would have been able to dispense at that time. The nurse was able to dispense Norco on 09/18/24 in the evening from the e-kit and Norco was delivered from the pharmacy in the morning on 09/19/24.

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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. 38893 Based on observations, interviews and record reviews, the facility failed to provide foods prepared, served, and stored under sanitary conditions and in accordance with professional standards for food safety. The findings included: 1. During the initial kitchen tour, on 09/16/24 at 9:08 AM, accompanied by the Registered Dietitian (RD) and the Certified Dietary Manager (CDM), the following was noted: a. The concentration of chlorine used for sanitizing wares in the mechanical ware washing machine was less than 50 parts per million. b. The temperature of the wash, rinse and sanitizing cycles did not reach 120 degrees Fahrenheit (F). c. There was an accumulation of mold in the basin of the ice machine. d. The wall behind the coffee stations was damage. e. There was an accumulation of residue on the knobs of the range and convection oven handles. f. There was a red bucket of sanitizer kept on a shelf directly over the oven and the flat top range. g. Foam containers that were stored in the tray assembly and the hot holding areas were not stored inverted to prevent dust and debris from falling in them. h. Small bowls were stored on a cart uncovered. i. There was an accumulation of ice on the curtains inside of the entrance to the walk-in freezer. j. The exterior wall of the walk-in cooler and freezer was dirty and had some spots of rust. k. The floor tiles that formed the baseboard along the wall of the walk-in cooler and freezer were not secured to the wall. l. Aluminum foil was used to line the shelving of a food preparation table in a processing area outside of the walk-in cooler. At the conclusion of the initial kitchen tour, the RD and the CDM acknowledged understanding of the findings. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) During a follow up visit to the kitchen, on 09/18/24 at 7:02 AM, accompanied by the CDM, Staff A, Dietary Aide, was observed portioning salads to be used for the lunch meal. It was noted that the Dietary Aide was removing lettuce from a bag with his bare hands. The Dietary Aide was instructed by the CDM to perform hand hygiene and don clean single use gloves. 3. During the follow up kitchen tour, on 09/18/24 at 11:11 AM, accompanied by the CDM, the following was noted: a. Staff A, Dietary Aide, Staff B, Dietary Aide, and Staff C, Dietary Aide, were observed rolling silverware in paper napkins and preparing to serve the lunch meal without a proper restraint to cover their beards. b. The handle of a wire whisk that was being used was damaged to a point that it was no longer cleanable. c. Staff D, Dietary Aide, was observed entering the kitchen and began handling and rolling silverware with bare hands and fingers in direct contact with the food and lip contact surface of utensils. d. An employee's personal clothing and lunch box were stored on a shelf with single use and disposable wares. At the conclusion of the tour, the CDM acknowledged understanding of the findings.