

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2024
NAME OF PROVIDER OR SUPPLIER Jupiter Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 17781 Thelma Ave Jupiter, FL 33458	

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)
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29151</p> <p>Based on record review and interview, the facility failed to coordinate medication administration times with dialysis services for 2 of 3 sampled residents reviewed (Residents #1 and #6). In addition, the facility failed to ensure the completion of dialysis communication records to validate continuity of care for Resident #1.</p> <p>The findings included:</p> <p>1a) Clinical record review revealed Resident #1 was admitted to the facility on [DATE] for rehabilitation services. Resident #1's pertinent diagnoses included End Stage Renal Disease, Metabolic Encephalopathy and Diabetes.</p> <p>Medication Administration Records (MAR) dated 05/2024 and 06/2024 indicated Resident #1 did not receive the following medications as prescribed. The explanation documented by the nursing staff noted, Resident in Dialysis:</p> <p>On 06/08/24 Calcium Acetate 667 mg, Ipratropium Nebulizer and Zinc 220 mg.</p> <p>On 06/04/24 Megestrol Acetate Suspension 40 MG/ML, give 5 ml by mouth one time a day for poor appetite for 3 Days.</p> <p>On 05/25/24 Calcium Acetate (Phos Binder) Oral Capsule 667 MG.</p> <p>The facility failed to coordinate medication administration with dialysis care to prevent medication omissions.</p> <p>Interview with the Risk Manager who assisted in navigating the electronic record on 07/08/24 at approximately 5:20 PM confirmed the findings.</p> <p>1b) Review of the facility documents titled, Dialysis Transfer Form which documented the resident's assessment pre and post dialysis treatment revealed the nursing staff failed to document the assessment post dialysis treatment on 05/25/24. The post assessment form captures condition of the access site, vital signs, signs and symptoms of infection and any additional comments.</p> <p>(continued on next page)</p>

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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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Risk Manager conducted on 07/08/24 starting at 4:42 PM, who assisted in locating the missing information, revealed the facility checks vital signs every shift, there is no other documentation regarding the access site (Catheter) or signs of infection after the dialysis treatment.</p> <p>The nursing staff failed to document medications given to the resident pre dialysis treatment on 05/21/24, 05/30/24 and 06/01/24. Interview with the Risk Manager conducted on 07/08/24 starting at 4:42 PM confirmed the medication section was left blank.</p> <p>Record review revealed the nursing staff failed to document a pre dialysis assessment including code status, mental status, allergies, medications given, condition of access site, vitals signs and signs of infection on 06/04/24 and 06/06/24. The nursing staff failed to document the assessment post dialysis treatment on 06/06/24.</p> <p>Interview with the Risk Manager conducted on 07/08/24 starting at 4:42 PM , who assisted in locating the missing information revealed the facility checks vital signs every shift, there was no other documentation regarding the other elements noted on the assessment form.</p> <p>Further record review revealed the nursing staff failed to document a pre dialysis assessment including code status, mental status, allergies, medications given, condition of access site, vital signs and signs of infection on 06/08/24. The nursing staff failed to document the assessment post dialysis treatment on 06/08/24. The assessment captures the condition of the access site, vital signs, signs and symptoms of infection and any additional comments.</p> <p>Interview with the Risk Manager conducted on 07/08/24 starting at 4:42 PM, who assisted in locating the missing information revealed the facility checks vital signs every shift, there was no other documentation regarding the other elements noted on the assessment form.</p> <p>2) Clinical record review revealed Resident #6 was admitted to the facility on [DATE] with diagnosis of End Stage Renal Disease and was receiving dialysis services at the onsite dialysis facility.</p> <p>Physician's orders and Medication Administration Records (MAR) dated 06/06/24 revealed the nursing staff failed to administered the following prescribed medications:</p> <p>Hydralazine 100 mg, hold for systolic blood pressure less than 120 (9AM and 1 PM doses);</p> <p>Clonidine 0.1 mg (9 AM and 1 PM dose); Carvedilol 3.125 mg (9 AM dose);</p> <p>Nifedipine 60 mg (9 AM dose).</p> <p>The reason noted Resident has dialysis today.</p> <p>The blood pressure documented 7-3 shift as 176/87 and pulse 66.</p> <p>The record failed to provide evidence of provider orders to hold the blood pressure medication on dialysis days.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In addition, Medication Administration Record and Notes dated 05/29/24 indicates the nurse repeated the pattern, of holding blood pressure medications, and noted reason Resident has dialysis within 20 hours.</p> <p>Interview with the Risk Manager on 07/08/24 at approximately 5:30 PM revealed most likely the nurse held the medication because the resident was having dialysis and blood pressure may drop during treatment. The Risk Manager confirmed there were no others to hold the medications.</p> <p>Based on record reviews and interviews, the facility failed to coordinate medication administration times with onsite dialysis treatments to ensure all medications were administered as ordered. In addition, the facility failed to ensure accuracy and completion of the dialysis communication forms.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>29151</p> <p>Based on policy review, record review and interview, the facility failed to ensure licensed nurses were able to demonstrate competency related to following physician's orders for medication administration and documentation for 1 of 3 sampled residents (Resident #1).</p> <p>The findings included:</p> <p>Facility policy titled, Administering Medications, last revised April 2019 documents as follows:</p> <p>Policy Statement</p> <p>Medications are administered in a safe and timely manner, and as prescribed.</p> <p>2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions.</p> <p>3. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions.</p> <p>4. Medications are administered in accordance with prescriber orders, including any required time frame.</p> <p>5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:</p> <p>a. enhancing optimal therapeutic effect of the medication;</p> <p>b. preventing potential medication or food interactions; and</p> <p>c. honoring resident choices and preferences, consistent with his or her care plan.</p> <p>7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).</p> <p>8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns.</p> <p>10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary.</p> <p>20. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication.</p> <p>21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.</p> <p>22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.</p> <p>Clinical record review of Resident #1 revealed physician's orders dated 05/17/24 for Midodrine HCl Tablet 5 MG, Give 1 tablet by mouth two times a day for orthostatic hypotension. Hold if Systolic Blood Pressure (SBP) greater than 130.</p> <p>The Medication Administration Records revealed the following:</p> <p>On 05/19/24, 5 PM dose, the Midodrine was given with blood pressure 136/58.</p> <p>On 05/21/24, 5 PM dose, the Midodrine was given with blood pressure 143/70.</p> <p>On 05/24/24, 9 AM dose, the Midodrine was given with blood pressure 138/58.</p> <p>On 05/29/24, 5 PM dose, the Midodrine was held with blood pressure 126/68.</p> <p>On 06/01/24 9 AM dose, the Midodrine was held with blood pressure 128/61.</p> <p>Physician's order dated 05/21/24 documents Insulin Lispro Subcutaneous Solution Pen-injector 100 UNIT/ML, Inject 2 unit subcutaneously before meals for Steroid induced hyperglycemia GIVE INSULIN FOR GLUCOSE ABOVE 200.</p> <p>The Medication Administration Records revealed the following:</p> <p>On 06/04/24, 11 AM dose, the insulin was administered with blood sugar 125.</p> <p>On 06/05/24, 11 AM dose, the insulin was administered with blood sugar 115.</p> <p>On 06/07/24, 11 AM dose, the insulin was administered with blood sugar 88.</p> <p>On 05/31/24, 11 AM dose, the insulin was administered with blood sugar 106.</p> <p>On 05/29/24, 11 AM dose, the insulin was administered with blood sugar 120.</p> <p>On 05/27/24, 6 AM dose, the insulin was administered with blood sugar 141.</p> <p>(continued on next page)</p>		

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