STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105555	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jupiter Rehabilitation and Healthcare Center	17781 Thelma Ave Jupiter, FL 33458

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide maintenance and housekeeping services and linens in a manner to provide a clean, sanitary and homelike environment. The findings included:A. During an observation in the Main Dining Room, on 07/07/25, at the conclusion of the initial kitchen tour, at approximately 9:40 AM, there was a plastic folded table stored between a snack vending machine and the wall that had an accumulation of food residue and debris. The Food Services Director/Certified Dietary Manager (CDM) had the table removed by staff. B. During the initial pool process, beginning on 07/07/25 at approximately 9:45 AM, the following were noted: a. In room [ROOM NUMBER], there was a soiled gown that was left in the shower b. In room [ROOM NUMBER] there was an accumulation of debris on the floor at the hand washing sink, under the resident’s bed and on the fall mat for Resident #61’s bed (window bed). 3. In room [ROOM NUMBER], there was an accumulation of debris on the floor at the hand washing sink and under the resident’s bed. C. During an observation of the Main Dining Room, on 07/09/25 at 7:33 AM, the following were noted: a. A trash container by the entrance to a screened in patio was approximately 1/3 full of from the previous day and had an odor, The CDM agreed that the refuse container smelled foul. b. There were accumulations of food residue and stains on the tablecloths on 8 of the 18 tables. During an interview, at the time of the observation, the CDM stated that housekeeping was responsible for emptying the trash containers and the kitchen was responsible for changing the linens on the tables. On 07/10/25 at 12:35 PM, the Surveyor attempted to contact the pest control company that provided services to the facility and a voice message was left. There was no response from the pest control company (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Upon entering the room for Resident #37 and #39 on 07/07/25 at 10:50 AM, a strong urine odor was noted. The large room contained four beds. The urine odor became stronger near the two beds located at the back of the room, the beds belonging to these two residents. Resident #39 was not in the room during this observation, but the area near her bed revealed the strong odor. The bed for Resident #39 was a low bed with a specialty air mattress, that was flanked by two regular thick mattresses used as fall mats. Both Residents #37 and #39 were totally dependent upon staff for all care needs. During an interview on 07/07/25 at 11:27 AM, Resident #45 voiced a concern that there was less staff on the weekends. The resident explained that during the week there were four housekeepers, one for each unit, but on the weekends, there were only two. The resident voiced it took longer to get their rooms cleaned and they weren't cleaned as well as during the week. She voiced concerns with picking up germs and stated she had to be careful because it wasn't as clean as it could be. An observation on 07/08/25 at 3:46 PM revealed Resident #39 lying on the thick mattress on the floor to the left side of her bed. The resident was uncovered, wearing a top with an adult brief, moving about the mattress with involuntary jerky movements. A large wet spot was noted on the fitted sheet under the resident. The urine odor remained in the room. Staff B, Certified Nursing Assistant (CNA), was sitting in a chair watching her, as the resident had been put on one-to-one observation. Upon entering the room, the CNA stated, she's a tough one. On 07/09/25 at 9:59 AM, Staff A, CNA, was sitting with Resident #39. Staff A confirmed she smelled the urine odor. When asked why there was an odor in the room, the CNA stated they don't have any incontinent pads for the beds, so when the resident urinates, it goes through the fitted sheet and into the mattress. When asked if they had either the plastic or cloth pads the CNA stated they had none. An observation of all four laundry carts, one on each hall, on 07/09/25 at 10:12 AM, lacked any incontinence pads. During an interview at that time, the Housekeeping Director stated they do have the cloth incontinence pads, and that they were put out on the carts that morning. When told there was none available to staff at the present time, the Housekeeping Director stated they must be in the laundry. Observation in the laundry revealed a large bin of dried linens. Staff stated there were some incontinence pads in that bin. Only one was observed at that time, although staff did not dig into the pile of clean laundry. The Housekeeping Director explained the carts were restocked during lunch for linen use in the afternoon. Upon entering the room of Resident #39 on 07/09/25 at 12:24 PM, the urine odor was noted. Resident #39 had finished lunch, and a large puddle was noted under her Broda chair (a specialty recliner type wheelchair). When asked if the observed puddle was urine, Staff A confirmed it was and explained the resident's adult brief doesn't stay in place because of her movements. The CNA was placing fitted sheets on the resident's bed and mattress to the left. Observation revealed the sheets were threadbare in larges spots on one of the sheets, and over approximately a quarter of the second sheet. Photographic Evidence Obtained. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/10/25 at 11:35 AM, the Housekeeping Director explained there was a deep cleaning schedule so that all rooms were deep cleaned at least once a month. When asked about the process for odorous rooms and or mattresses, the Housekeeping Director explained they would clean the rooms as needed and the Maintenance Director, who was also present at that time, stated they would replace the mattresses as needed. When asked if he had changed out any mattresses that week, the Maintenance Director was not sure. When asked about the room for Resident #37 and #39, the Maintenance Director thought they had changed out the mattresses but was unsure when. The Directors were informed of the concerns observed and smelled throughout the week. An observation was made of the room at that time, with the two Directors, who both agreed with the findings. When shown the photo of the threadbare sheets that were used, the Housekeeping Director stated those sheets should never have made it back to the floor and the CNAs should not have used them. During an interview on 07/10/25 at 11:45 AM, the Administrator (NHA), stated the specialty air mattress used for Resident #39 was a rental mattress, and that it had not been changed out since arrival on 06/19/25. An observation on 07/10/25 at 12:56 PM of all four laundry carts on the four units lacked any incontinence pads. An observation in the laundry at that time revealed a total of 9 cloth incontinence pads available for staff use and being restocked on the carts. Photographic Evidence Obtained. Laundry staff said there are some in the one cart being folded, and in the dryer, although none were observed. During an interview at that time, the Director of Nursing stated the cloth incontinent pads were for use on all the beds, and the plastic ones were used during wound care. During a supplemental interview on 07/10/25 at 12:59 PM, the Housekeeping Director stated she always has a box of cloth incontinent pads available in storage so that she could replace them as needed. When asked why they are not available on the carts for the staff to use she currently, the Director stated, Just because I keep getting pulled in different directions. Class III

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observation and interviews, the facility failed to file a grievance in a timely manner, for 1 of 1 sampled resident reviewed for grievances. As evidenced by failure of staff to respond to Resident #46's grievance regarding her missing blankets for almost 2 weeks.The findings included:The facility policy titled, Resident and Family Grievances documented in part Grievances can be voiced in the following forums: a. Verbal complaint to a staff member or grievance official.Record review revealed Resident #46 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, on a 0 to 15 scale, indicating mild cognitive impairment. During an interview on 07/07/25 at 11:24 AM, Resident #46 stated, I'm missing my two blankets, The blue one my grandson got for me. I've been missing them for over 1 week. I have told several staff, but they do nothing. I even went out to the nurses' station and told them, but nothing happened.During an interview on 07/08/25 at 11:09 AM, when asked did you speak to anyone about your missing blankets. Resident #46 stated, Yes, I spoke to the person over housekeeping finally on yesterday afternoon after complaining to three or four other people.During an interview on 07/09/25 at 1:45 PM when asked did they find your blankets. Resident #46 stated No, the housekeeping director hasn't come back to talk to me about them. During an interview with the Social Worker (SW) on 07/10/25 11:56 AM she was asked are grievance forms available for staff to fill out when a resident has a complaint, she stated Yes, the forms are at the nurses station, in the conference room, and in my office. When asked, do you know anything about the missing blankets for Resident #46. The SW stated Housekeeping was given the grievance. I just found out yesterday. I have to call her family to see if maybe they took them home to wash. A copy of the grievance form was requested from SW. The grievance form was dated 07/08/25, the top portion of the form with the resident's information and complaint was filled out, there was no other documentation on the form. (photographic evidence obtained)During a conversation with the Housekeeping Director (HD) and the SW, The HD was asked by the SW if she had an update on Resident #46's missing blankets. The HD stated, no, after lunch I will show the resident all the blankets I have and maybe she can identify hers. The SW stated, I'm going to go call the family now. During a brief conversation with the SW on 07/10/25 at 2:01PM, she stated I spoke to Resident #46's son and he said the family does not have the blankets and the resident had been complaining to him that the blanket that her grandson got for her is missing. I didn't see a blanket listed on the resident's inventory.

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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** Based on record review and interview, the facility failed to ensure accurate Minimum Data Set (MDS) assessments for 1 of 5 sampled residents, Resident #39, related to antipsychotic use, and for 1 of 10 sampled residents, Resident #37, related to weights.The findings included:1) Review of the record revealed Resident #39 was admitted to the facility on [DATE]. Review of the current comprehensive MDS assessment dated [DATE] documented the resident was taking an antipsychotic medication, and that a Gradual Dose Reduction (GDR) for the antipsychotic was both attempted on 01/14/25 and was contraindicated on 01/14/25.Further review of the record revealed Resident #39 was ordered Risperdal, an antipsychotic medication, since 08/11/22, and that the dose of the medication had not been changed. Further review of the psychiatric progress noted dated 01/14/25 documented the dosing of the Risperdal should be done by neurology as the medication was ordered for a neurological condition, Huntington's disease. This progress note lacked any contraindication to a GDR for the Risperdal.During a side-by-side record review and interview on 07/09/25 at 10:35 AM, the MDS Coordinator confirmed the findings, further stating the resident's Ativan, an antianxiety medication and classed as a psychotropic medication, not an antipsychotic medication, was discontinued at that time. The MDS Coordinator stated there had not been a change in the antipsychotic medication since 2022 and she was unable to locate any contraindication for a GDR on 01/14/25, as incorrectly documented on that MDS assessment.2) Review of the record revealed Resident #37 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE], documented in section K that the resident weighed 134 pounds. Further review of the electronic medical record revealed on 05/07/25, the most current weight prior to the assessment date, documented the resident weighed 132 pounds.During an interview on 07/09/25 at 1:11 PM, when asked how she obtained weights for section K of the MDS assessment, the Registered Dietician (RD) stated she gets the weights directly from the electronic medical record and uses the weight right before the assessment date. When told of the inconsistency between the weight in the assessment and the weight in the electronic medical record for Resident #37, the RD stated she would review the concern. During a supplemental interview on 07/09/25 at 1:25 PM, the RD agreed with the finding.

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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** Based on observations, interviews and record reviews, the facility failed to develop and implement a care plan to address Post Traumatic Stress Disorder (PTSD) for 1 of 1 sampled resident reviewed for Behavior, Resident #61; The facility failed to develop and implement a care plan for 1 of 5 sampled residents reviewed for unnecessary medications, Resident #63. The findings included: Resident #61 was admitted to the facility on [DATE]. According to the resident’s most recent complete assessment, an Annual Minimum Data Set (MDS) with a reference date of 05/31/25, Resident #61 had a Brief Interview for Mental Status (BIMS) score of 03, indicating a severe cognitive impairment. The assessment documented that the resident was dependent upon staff for all activities of daily living (ADLs). Resident #61’s diagnoses at the time of the assessment included: Non-Alzheimer's dementia, Anxiety disorder, Psychotic disorder, Post Traumatic Stress Disorder (PTSD). A review of Resident #61’s medical records revealed that there was no care plan to address the resident’s PTSD. During the survey process, it was determined that the resident was not interviewable due to multiple attempts to interact with the resident and the resident did not respond to being greeted by name on multiple occasions. During an interview, on 07/09/25 at 9:30 AM, with Resident #61’s Power of Attorney (POA), when asked about the resident's PTSD, Resident #61’s POA replied, he was in Vietnam. When asked about triggers and what should be avoided, Resident #61’s POA replied, loud noises, fireworks, things like that. During an interview, on 07/09/25 at 1:59 PM, with Staff F, RN, when asked about Resident #61's PTSD, Staff F replied, I am assuming he was in the military, I am not sure of the underlying reason.” When asked about triggers and what should be avoided, the RN replied, “Probably not getting what he wants, or forgetting his tray and he will feel like he is abandoned. They are very good with him and with getting him in his chair. I have only been here for about a month and a half.” During an interview, on 07/09/25 at approximately 2:30 PM, with Staff G, LPN, when asked about providing care to Resident #61, Staff G replied, he is okay, he is not violent. Sometimes when you provide care, he is combative and then you can talk to him, and he will calm down. When asked about Resident #61 having PTSD, Staff G replied, “they have a past history of anxiety, he had a stroke and has left sided weakness.” During an interview, on 07/09/25 at 3:50 PM, with Staff H, CNA, when asked about Resident having PTSD, Staff H replied, I did not know he had PTSD. During an interview, on 07/09/25 at 3:54 PM, with the MDS Coordinator, since 06/03/25, the MDS Coordinator acknowledged that there was no care plan to address Resident #61's PTSD prior to Surveyor intervention. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 07/09/25 at 3:59 PM, with the Social Services Director (SSD), when asked about a care plan to address Resident #61’s PTSD, the SSD acknowledged that there was no care plan to address Resident #61's PTSD prior to the Surveyor bringing it to her attention. 2) A review of the clinical records indicated that Resident #63 was admitted to the facility on [DATE], with a diagnosis of anxiety disorder. A physician's order dated 06/04/2025, revealed that the resident had been prescribed NovoLog Injection Solution 100 UNIT/ML (Insulin Aspart) 4 units to be injected subcutaneously before meals for diabetes. The order also stated that the medical doctor or nurse practitioner should be contacted if blood sugar levels exceed 300 mg/dL. On 06/26/2025, the interdisciplinary team reviewed the residents' care plans, but no specific care plans were developed for the diagnosis of diabetes or for the use of insulin. During an interview on 07/09/2025 at 2:14 PM, the MDS Coordinator confirmed that no active care plan addressing the resident's diabetes diagnosis or insulin usage.

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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** Based on record review, the facility failed to update the care plan for 2 of 28 sampled residents, as evidenced by failure to ensure that the diet orders were care planned for Resident #50 and failure to ensure the antianxiety medication care plan for Resident #63 was updated.The findings included: 1) Record review revealed Resident #50 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE] documented that a Brief Interview for Mental Status (BIMS) was not conducted, because the resident was rarely or never understood. Review of a physician order's dated 06/02/25 for Resident #50, indicated that the resident was prescribed a diet of regular, pureed (pudding like) texture, and nectar thickened fluid consistency. Review of the revised care dated 06/12/25, indicated that Resident #50 was on a regular, mechanically altered ground texture, and nectar thickened liquids consistency diet. 2) A review of the clinical records indicated that Resident #63 was admitted to the facility on [DATE], with a diagnosis of anxiety disorder. A review of a physician's order dated 06/18/2025, revealed that Alprazolam 0.5 mg was prescribed to be given as one tablet by mouth every 12 hours as needed for anxiety for 7 days. Additionally, a review of the care plans, with a revision date of 06/26/2025, noted that Resident #63 uses anti-anxiety medications related to anxiety disorder. However, it was identified that there was no current order for anti-anxiety medication in place. The care plan was not updated to reflect the resident's current status. On 07/09/2025 at 2:14 PM, the MDS Coordinator was interviewed, who confirmed an active care plan for anti-anxiety medication. Still, no current order has been issued for it.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure that 1 of 1 sampled resident reviewed for skin rash received further treatment as evidenced by Resident #35 remained symptomatic after the initial treatment for a skin rash.The findings included:Record review revealed that Resident #35 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview Mental Status score of 07 on a 0-15 scale, indicating severe cognitive impairment.During an interview on 07/07/25 at 9:45 AM with Resident #35, she was observed scratching the left side of her face. A rash was noted to her left cheek area. When asked are the staff putting any medication on your face for the itching, she stated, I don't think so. Review of a physician progress note dated 07/05/25, revealed that the attending nurse practitioner (NP) visited Resident #35 on 07/04/25 due to a skin rash and the resident was noted to have a mild to moderate skin rash. The NP's plan was to prescribe Permethrin 5 % (for treatment of scabies) cream for a one-time dose and reevaluate the rash after treatment for effectiveness. During an interview with Resident #35 at 07/09/25 at 8:32 AM, when she was asked how the rash on her face is, the resident stated It itches and that's not the only area the rash is on, it's all on my neck. It feels like something is biting me. When asked had the staff applied any medication for the itching, Resident #35 stated, No. During a skin assessment on 07/09/25 at 1:30 PM with Staff I, Certified Nursing Assistant (CNA) at the bedside, Resident #35 was noted to have several scabbed and reddened areas to the skin on her neck, upper back, bilateral arms, chest area, and the left side of her (UM)face.During an interview on 07/09/25 at 1:38 PM with the Unit Manager, (UM) she was asked if Resident #35 had received any treatment for a skin rash. She looked in the resident's record and printed out a treatment record that indicated the resident had received a one-time treatment of Permethrin cream on 07/06/25. When asked if she knew if the resident had any other treatments for itching ordered or when will she be reassessed by the nurse practitioner (NP), she stated No, she doesn't have any other treatment ordered. The UM read the progress note in the resident's record written by the NP on 7/05/25. Suddenly, she placed a call to the NP and asked her when she will follow with Resident #35 for reassessment of the skin rash as stated in her note. The UM stated, The NP said she usually follows up with the resident seven days following treatment and the resident should be seen by dermatology. When asked if or when will Resident #35 be seen by dermatology, she stated I will have to let you know. The UM did not give any follow up information regarding the dermatologist. During an interview on 07/09/25 at 1: 58PM with the Medical Director of the facility, she was made aware of the NP's response to the UM stated that she will follow up with Resident #35 seven days after her prescribed treatment for a skin rash and the resident should be seen by dermatology. When asked what happens if the resident is still having symptoms of itching and when will dermatology see the resident, the Medical Director stated, We do have a dermatologist that comes to the facility, but the resident doesn't have to wait, I can see her.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to follow physician orders for treatment of a facility acquired pressure ulcer for 1 of 3 sampled residents reviewed for pressure ulcers, as evidenced by not changing the dressing, as ordered for Resident #13 pressure ulcer.The findings included: Record review revealed Resident #13 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 02, on a 0-15 scale, indicating severe cognitive impairment. Review of a pressure injury investigation audit form dated 06/30/25, indicated that Resident #13 had a new left heel pressure ulcer (caused by unrelieved pressure). Review of a physician order dated 07/03/25 for Resident #13, instructed staff to cleanse the right achilles (heel) pressure wound with normal saline (salt solution), apply skin prep to the necrotic area and cover with a foam dressing every day shift (7 AM to 3 PM) on Monday, Wednesday, and Friday. A second order dated 07/03/25, instructed staff to cleanse the right achilles pressure wound with normal saline, apply skin prep to the necrotic area and cover with a foam dressing as needed for saturation or dislodgment of the dressing. During an observation on 07/08/25 at 3:30 PM, Resident #13 was sitting in her wheelchair with her right leg elevated, the tan foam dressing noted to her right achilles was partially hanging off and exposing the wound. (photographic evidence obtained)During an observation on 07/09/25 at 8:48 AM, Resident #13 was lying in her bed with a tan foam dressing dated 07/04/25 to her right achilles that was partially hanging off. (photographic evidence obtained)On 07/09/25 at 1:21 PM, Resident #13 was observed sitting in her wheelchair with tennis shoes on both feet. The foam dressing that should have covered the wound to her right achilles was above the back of the shoe. (photographic evidence obtained) Review of the Treatment Administration Record (TAR) for Resident 13, revealed that Staff L, Licensed Practical Nurse (LPN) had signed the TAR acknowledging that she had performed the wound care treatment to Resident #13 right achilles pressure wound, on 07/07/25 and 07/09/25. During an interview on 07/09/25 at 4:22PM, Resident # 13 was noted sitting on the edge of her wheelchair with her right leg elevated. She was wearing a tennis shoe to her right foot, but the shoe from the left foot was on the bed. The resident was mumbling trying to say something and grimacing as if she was having discomfort. When asked if she was having discomfort, Resident #13 pointed to her right foot and shook her head yes. Staff K, Licensed Practical Nurse (LPN) was made aware of the resident's complaint of discomfort to her right foot. She went into the resident's room. Staff K, LPN removed the foam dressing that was hanging off the resident's right achilles wound. The dressing that was removed had the date 7/4 and the initials { } written on it. There was some dark brownish drainage noted on the dressing and the dressing had a foul odor. The wound was noted to have eschar (dark color). Staff K, (LPN) stated I'm going to put on a new dressing and give you some pain medication. Resident #13 shook her head yes.

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Jupiter Rehabilitation and Healthcare Center	17781 Thelma Ave Jupiter, FL 33458

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, record review, and interview, the facility failed to ensure care and services, and supervision to prevent falls, for 1 of 4 sampled residents, as evidenced by Resident #39 having had eight falls since 05/01/25, with six being from her chair. The three most recent falls occurred while Resident #39 was in her Broda chair, the newest of intervention as of 06/19/25. The facility also failed to ensure the provision of two neurology consults for increased involuntary movements related to Huntington's Disease, which was care planned as part of the resident's risk for falls.The findings included:Review of the policy Fall Prevention Program (not dated), documented in part, Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. 4. Risk Protocols: . g. Provide interventions that address unique risk factors: medications, psychological, cognitive status, or recent change in functional status. h. Provide additional interventions as directed by the resident's assessment, including but not limited to: . ii. Increased frequency of rounds iii. Sitter, if indicated . Review of the record revealed Resident #39 was admitted to the facility on [DATE], with diagnoses to include Huntington's Disease, repeated falls, and abnormal involuntary movements. Review of the current Minimum Data Set (MDS) comprehensive assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 0, on a scale of 0 to 15, indicating severe cognitive impairment. This MDS assessment documented the resident was totally dependent upon staff for all Activities of Daily Living (ADLs) and had two or more falls since the prior assessment of 12/29/24.Review of the current physician orders include a neurology consult dated 10/29/24 for increased involuntary movements related to Huntington's Disease. The record lacked any evidence that the consult had been completed, and it remained an active order in the record at the time of the survey.A current care plan initiated on 09/09/20 documented in part that Resident #39 was at further high risk for falls with injury related to ongoing progressive loss of functional abilities. This care plan included an intervention dated 05/09/25 for a neurology consult.All Fall Risk Assessments in the medical record documented Resident #39 as a high risk for falls. The Risk Manager was asked to locate and provide evidence of the investigation for all falls from 05/01/25 to the present time.Review of progress notes and post-fall investigations revealed the following:a) On 05/09/25 at 2:45 PM Resident #39 was found on the floor, having slid off her chair. The root cause analysis was that the resident had Huntington's Disease with involuntary movements with an evaluation for a Geri-chair (a recliner-type wheelchair).b) On 05/12/25 at 11:00 AM Resident #39 was sitting on her bed and slipped off the bed onto the floor. The root cause analysis was documented as the resident had Huntington's Disease that caused her to roll off the floor mat and onto the floor. This contradicted the documented eyewitness statement by the Staff Developer who saw the resident slip off the bed and the mattress was in an upright position and not on the floor during the event. Therapy services were to evaluate for a Geri-chair.A physician's progress note dated 05/12/25 at 1:48 PM documented, in part, . Assessment/Plan: . Huntington's disease: . needs close supervision secondary to involuntary movements.c) A progress note dated 05/12/25 at 2:26 PM documented, Observed resident on floor next to bed. The facility did not provide any investigation for this event. A subsequent physician's progress note dated 05/13/25 at 12:03 PM documented the resident found to have 2 falls in the last 24 hours . Fall prevention protocols. Continue with nursing supervision. Follow neurology. Continue supportive treatment.d) On 05/20/25 at 8:35 AM, Resident #39 was sitting in her chair, waiting for breakfast, during meal tray pass. As per a witness statement, staff turned around and observed the resident on the floor. Resident #39 was placed on frequent checks of every 15 minutes, for 24 hours. A physician's progress note dated 05/20/25 at 2:55 PM documented the fall that morning with no injury. This note documented, in part, . Assessment/Plan: . Huntington's disease: . needs close supervision secondary to involuntary movements.e) On 05/27/25 at 11:55 AM Resident #39 was on the floor, having fallen out of the chair. The root cause analysis was that the resident kicked the footboard of the wheelchair and slid out of the chair. An intervention was again to evaluate for a Geri-chair.f) As per an invoice provided by the Administrator, Resident #39 was provided a new Broda chair (a specific recliner-type wheelchair) on 06/19/25. Note the evaluation for a new chair was made on 05/09/25.g) On 07/04/25 at 12:09 PM Resident #39 was found on the floor in the hallway, next to her chair. The root cause analysis was that the resident sat up and slid out of the chair, although the progress note revealed the resident had been seen in the chair, appropriately placed, and with the footrest up.h) On 07/08/25 at 7:50 AM Resident #39 was found on the

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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** Based on policy review, observation, interview, and record review, the facility failed to ensure the provision of foods to address nutritional concerns for 2 of 10 sampled residents, as evidenced by the failure to include fortified foods as ordered for Resident #37 and Resident #50 , and failure to provide ordered meals for Resident #63. All three sampled residents had weight loss concerns or were underweight.The findings included:Review of the policy Fortified Foods (not dated) documented, in part, Policy: . The purpose of utilizing fortified foods is to add additional calories/protein to the oral diet in efforts to address weight loss, skin status, nutritional concerns, etc. 1) The fortified foods are to be added to the resident's diet includes but not limited to fortified cereal and fortified potatoes. 1) Review of the record revealed Resident #37 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 2, on a 0 to 15 scale, indicating the resident was severely cognitively impaired. The same assessment documented the resident was totally dependent upon staff for all activities of daily living (ADLs). Although the weight for Resident #37 had been stable for the past six months, the current quarterly nutritional assessment documented the resident was underweight for her age and was at risk for malnutrition. An order dated 09/19/22 documented the resident was to receive fortified foods with all meals. An observation on 07/07/25 at 12:09 PM revealed Resident #37 had received her lunch meal. The meal ticket documented fortified foods with all meals. The meal provided to the resident lacked any fortified potatoes or any other fortified food. Observation of the meal at 12:38 PM still lacked any fortified foods. Staff A, Certified Nursing Assistant (CNA) was placing the tray back into the cart and stated, She drank everything, but only ate like 15% of the food. During an observation on 07/08/25 at 12:18 PM, the lunch meal was provided to Resident #27. The meal consisted of a slice of turkey, a sweet potato, green beans, and diced pears. The tray lacked any fortified foods, and the meal ticket still documented the resident was to have fortified foods with all meals. During an interview on 07/09/25 at 12:55 PM, the Registered Dietician (RD) and Administrator (NHA) were made aware of the observation from Monday's lunch on 07/07/25 and shown the photo of Tuesday's lunch, both of which lacked fortified foods. The RD agreed with the findings. Both managers were surprised, and the NHA stated the kitchen was pretty good with the fortified foods. 2) A review of clinical records revealed Resident #63 was admitted to the facility on [DATE], with a diagnosis of malnutrition. The admission Minimum Data Set assessment (MDS), dated [DATE], indicated a brief interview for mental status, scoring 12, which suggested that the resident was moderately cognitively impaired. The diet order, issued on 06/04/2025, specified a no-added-salt diet with a regular texture and thin liquid consistency. A nutrition assessment conducted the same day revealed that the resident’s body mass index (BMI) indicated he was underweight for his age. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional records indicated that the resident had experienced weight loss. Specifically, on 06/14/2025, his weight was recorded at 148.3 pounds, but by 07/04/2025, it had dropped to 138.2 pounds. The care plan was revised on 06/26/2025 and noted that the resident was at risk for malnutrition, muscle wasting, and altered nutrition. It highlighted his low BMI and the need for fortified foods. The intervention outlined was to provide the diet as prescribed. On 07/07/2025 at 10:22 AM, the interview process began with Resident #63. He expressed he had weight loss and stated that he found the food to be awful and terrible, adding that it was often presented as if the staff had piled the food on his plate disorderly. He also complained that the meals were served cold. Later, at 12:55 PM, a follow-up occurred while the resident was having lunch. He mentioned, “Today he was supposed to have spaghetti with meat sauce, but he didn’t receive any spaghetti.” He then showed the surveyor his meal ticket, which indicated spaghetti with meat sauce, while his plate lacked spaghetti. On 07/09/2025 at 8:35 AM, a follow-up observation during breakfast the resident voiced his dissatisfaction again, noted that he had received meat sauce without spaghetti on Monday. The registered dietitian (RD) was interviewed on 07/10/2025 at 12:03 PM. The surveyor informed her about the resident's food concerns and showed her a picture of the meal ticket and what the resident had received. The RD remarked, “If he got the meat sauce, he should have also received the spaghetti,” she acknowledged the issue. 3)Record review and observations revealed that Resident #50 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE], documented that a Brief Interview Mental Status was not conducted, because the resident was rarely or never understood. Review of Resident #13 medical diagnosis revealed a history of Alzheimer's (memory loss), anorexia nervosa (eating disorder causing one to be obsessed about weight), and dysphagia (difficulty swallowing). During an observation of Resident #50’s lunch tray on 07/07/25 at 12:28 PM, the meal ticket revealed that the resident was to receive fortified foods with all meals. The tray included: pureed meat sauce, vegetables and noodles. (photographic evidence obtained) Review of the weights for Resident #50 revealed, on 01/03/25, the resident weighed 86.8 pounds and on 07/03/25, the resident weighed 78.2 pounds which is a -9.91 % weight loss in 6 months. Review of the current diet order for Resident #13 dated 06/02/25, revealed that the resident was prescribed a regular diet, pureed texture, nectar thickened fluids consistency with a planned weight gain regimen to include fortified foods at each meal. Review of the revised care plan dated 06/12/25, revealed that Resident #13, was at risk for malnutrition and the need for fortified foods, there was a goal for the resident to maintain her weight or have gradual weight gain with no significant weight changes through the next review date and one of the interventions was to provide fortified cereal at breakfast and fortified mashed potatoes at lunch & dinner. During an observation of Resident #50 lunch tray on 07/08/25 at 12:20 PM, the meal ticket revealed that the resident was to receive fortified foods with all meals. The tray was noted to have sweet potato, turkey and green beans, pears. (photographic evidence obtained)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, observations, record review and interviews, the facility failed to ensure that it was free of medication errors for 3 of 7 sampled residents, as evidenced by a medication error rate of 15.6% with 32 opportunities due to failure to ensure that Resident #7 received medications ordered and was available for him, failure to ensure Resident #5 received medications that are prescribed to him, failure to notify the physician prior to holding blood pressure medications for Resident #27.The finding Included:The facility policy titled Medication Administration documented in part Policy Explanation and Compliance Guidelines 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medications for those vital signs outside the physician's prescribed parameters. 12. Compare medication source (bubble pack, rectal, etc.) with medication administration record (MAR) to verify resident name, medication name, form, dose, route, and time. (photographic evidence obtained)1.) Record review revealed Resident #7 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE], documented a Brief Interview Mental Status score of 09 on a 0-15 scale, indicating moderate cognitive impairment. During observation of medication administration on 07/08/25 at 9:05 AM, Staff J was observed preparing and administering medications for Resident #7. As she prepared the medications, she stated what each one of the medications were. After she prepared each medication, the name of the resident was verified with the medication label for each medication she prepared. Staff J, LPN poured Enulose (medication for increased ammonia) in a clear medicine cup and the resident's name was verified with the bottle. The bottle of Enulose was noted to have a different resident's name on the mediation label. The bottle of Enulose was given back toe Staff J, LPN and she placed it back in the medication cart. She placed a cup of five pills and a cup of Enulose on a white styrofoam tray and carried them to the resident's room. After Resident #7 put the pills in his mouth Staff J offered him a drink of water from a white styrofoam cup with a straw that was already sitting on his bedside table. During a brief conversation on 07/08/25 at 9:16AM, Staff J was asked to show the bottle of Enulose that she poured the dose from to administer to Resident #7. She went into the medication cart and handed the bottle of Enulose with another resident's name on the medication label, Staff J stated, I know it's not his, but! (photographic evidence obtained)Review of the physician orders for Resident #7 revealed an order that instructed staff to administer Glycolax powder/MiraLAX (for constipation) 17gm by mouth daily) mix with 8 ounces water, juice, coffee, tea) at 9:00 AM. A second order instructed staff to administer Enulose solution 30 milliliters by mouth three times a day for hyperammonia (increased ammonia). Review of the Medication Administration Record for Resident #7 revealed that Staff J signed acknowledging that she administered the Glycolax/Miralax on 07/08/25 at 9:04 AM. (Photographic evidence obtained)During an interview on 07/08/25 at 12:30 PM, when asked do you have a bottle of MiraLAX on your medication cart, Staff J, LPN opened the medication cart and pointed to the bottle of MiraLAX. When asked did any one of the residents that were observed doing med pass, have an order to get MiraLAX at 9:00 AM, Staff J, LPN looked at the medication administration record for the residents and stated Yes, Resident #7. When she was asked if she gave it to him, while she was being observed giving medications, Staff J stated, I gave it to him in his water. When was asked when, she stated, After you left. 2) Record review revealed Resident #5 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE] documented a Brief Interview Mental Status score of 12 on a 0-15 scale, indicating moderate cognitive impairment. During an observation on 07/08/25 at 9:18 AM, Staff J, LPN was observed preparing and administering medications for Resident #5. She prepared three pills in a clear medication cup, with each medication label being verified with the resident's name. Staff J, LPN was then observed administering the three pills in the medicine cup to Resident #5. Review of the physician orders for Resident #5 revealed an order that instructed staff to apply Triamcinolone Acetonide External cream 0.1% to affected areas daily for dermatitis (inflammation of skin). Review of the Medication Administration Record for Resident #5 revealed that Staff J, LPN signed on 07/08/25 at 9:22 AM acknowledging that she administered the Triamcinolone Acetonide External cream for the resident. (photographic evidence obtained) During an interview on 07/08/25 at 12:30 PM, Staff J, LPN was asked to show the Triamcinolone cream that she applied for Resident #5. She went to the treatment cart and looked throughout the cart and in the trash can and was unable to find the ointment. Staff J, LPN stated I can't find it 3) Record review revealed Resident #27 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE] documented a Brief Interview Mental

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to obtain a laboratory test for 1 of 5 sampled residents reviewed for laboratory testing. (Resident #8). The findings included: A review of the clinical record for Resident #8 revealed the resident was admitted to the facility on [DATE], with diagnoses of Anxiety Disorder, Depression, and Psychotic Disorder. A physician's order on the same day specified that Divalproex Sodium Oral Tablet Delayed Release 125 mg should be administered orally twice daily for mood disorder. Additionally, the physician ordered a valproic acid level to be measured on 06/01/2025. However, the records lacked documented evidence of the valproic acid test result.On 07/10/2025 at 12:29 PM, an interview was conducted with the Director of Nursing (DON), during which a side-by-side review of Resident #8's records occurred. The DON acknowledged the absence of the valproic acid result and promptly contacted the Unit Manager, requesting a follow-up with the laboratory service regarding the missing test. A subsequent interview with the DON at 1:40 PM confirmed that the result was still unavailable. She indicated that the unit manager had contacted the laboratory and was informed they did not have the result.Valproic acid is a test conducted when using the medication Divalproex. Levels are measured in the blood to ensure the medication is within the therapeutic range, which helps to ensure effectiveness while minimizing side effects. Elevated levels can suggest an increased risk of toxicity, potentially causing symptoms like nausea and drowsiness, or more serious issues like liver damage.Low levels may indicate that the medication is not sufficiently effective, which could increase the risk of seizures or mood swings.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. *Based on observations, interviews and record reviews, the facility failed to provide food that was prepared, stored and served in a sanitary manner in accordance with standards for food safety professionals. The findings included: The facility's policy 'Hand Hygiene' (no reference date) documented: Policy:All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.Policy Explanation and guidelines:6. Additional considerations:a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately removing gloves. 1. During the initial kitchen tour, on 07/07/25 at 9:11 AM, accompanied by the Food Service Director/Certified Dietary Manager (CDM), the following were noted:a. In the walk in cooler, a box containing raw shell eggs were stored directly over a box containing liquid pasteurized eggs.b. Cleaned and sanitized utensils were not stored inverted At the conclusion of the tour, the CDM acknowledged the concerns. 2. During a follow up visit to the kitchen, on 07/09/25 at 6:59 AM, accompanied by the CDM, Staff D, Cook, was asked about the food items that were in the steam table being served for breakfast. Staff D stated that she needed to change her gloves and walked away from the steam table. Staff D was observed going to a food preparation area where she took single use gloves from a box that was secured to the wall and returned to the steam table. During the observation, Staff D did not perform hand hygiene prior to getting and donning the gloves. The CDM acknowledged the concern and instructed Staff D to wash her hands and don a clean pair of gloves. 3. During a follow up tour of the kitchen, on 07/09/25 at 11:25 AM, accompanied by the CDM, the following were noted:a. There were several plates that were chipped in a manner that could cause skin tears to the residents. b. Staff E, Dietary Aide, was observed rinsing a knife in a food preparation sink and then placed the knife on a magnetic strip over the food prep table without properly cleaning and sanitizing the knife. When asked what the knife was used for, Staff E stated that she used it for cutting strawberries. When asked, Staff E acknowledged that she rinsed the knife and placed it back on the magnetic strip.c. Staff E was observed leaving the food preparation area through a door and returned to the food preparation area and took single use gloves from a box that was secured over the preparation table and sheets of parchment paper. Throughout the observation, Staff did not perform hand hygiene. Staff E acknowledged that she did not perform hand hygiene upon returning to the food preparation area and preparing for her next task by getting gloves and handling the parchment paper. The CDM acknowledged the concerns and instructed Staff E to wash her hands and don a clean pair of gloves.

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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** Based on policy review, observation, record review, and interview, the facility failed to ensure infection control practices for 3 of 30 sampled residents, as evidenced by the failure to abide by Transmission Based Precaution (TBP) guidelines, Enhanced Barrier Precaution (EBP guidelines, and failure to use Personal Protective Equipment (PPE) during direct care, for Resident #75, #288 and #71.The findings include:Review of the polices titled, Transmission-Based (Isolation) Precautions (TBP) and Enhanced Barrier Precautions (EBP) showed that the TBP policy documented, in part, 1. Facility staff will apply TBP….to residents who are known or suspected to be infected….3. (b). The provision of a private room as available/appropriate. 4. Residents… should remain in their rooms except for medically necessary care. The EBP policy documented, in part, targeted gown and gloves use during high contact resident care activities. 2.b. An order for EBP will be obtained for residents with any of the following (b)…. wounds, indwelling catheter, hemodialysis catheter…4. EBP should be used for high-contact resident care activities including providing hygiene. changing linen, and 1) Review of the record revealed Resident #75 was admitted to the facility on [DATE] with a diagnosis of fracture of left thigh bone. A review of the physician order dated 07/06/25 at 3:00 PM included placing the resident on contact isolation precaution to rule out Clostridium difficile colitis (C Diff) which is an infection in the large intestines. Review of the Physician Assessment/Plan dated 07/07/25 stated the following: “Diarrhea following recent antibiotics (doxycycline)- obtain stool sample to rule out C Diff, patient to remain on isolation until results (patient verbalize understanding)”. Review of the task list for bowel activity showed that Resident #75 had multiple loose stools from 07/02/25 to 07/06/25. Review of the facility lab book showed that the stool specimen was logged in as collected on 07/07/25. The following observations were made: On 07/07/25 at 9:30 AM, Resident #75 was observed in the hallway sitting in his wheelchair. On 07/08/25 at 12:30 PM Resident #75 was observed moving around the hallway while sitting in his wheelchair. On 07/08/25 at 4:30 PM Resident #75 was observed in a unit hallway by the nurse’s station. During the initial interview conducted with the Resident # 75, on 07/07/25 at 9:36 AM, when asked about the care and services of the facility, the resident responded, “I need to get my stool specimen results from Saturday.” The resident was in a private room and stated that he was moved to this room yesterday. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105555	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jupiter Rehabilitation and Healthcare Center	17781 Thelma Ave Jupiter, FL 33458

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 07/09/25 at 10:35 AM with the Unit Manager (UM). When asked to review the results for the C diff culture for Resident #75 the UM reviewed the electronic medical record and the results were not available. When asked how to confirm that the specimen was collected and sent for testing the UM stated that the specimen is logged in the lab book and the transporter signs the log sheet when the specimen is taken out for testing. On 07/09/25 at 5:43 PM an interview with the Infection Preventionist was conducted. This surveyor asked what the expectation was when a resident is on Contact Precautions pending lab results. The IP states that a resident should remain on contact precautions until the results are obtained. 2). Review of the record revealed Resident #288 was admitted to the facility on [DATE] with a diagnosis of [NAME] Kidney Disease requiring dialysis. A review of the physician order dated 07/01/25 at 3:00 PM included placing the resident on enhanced barrier precautions for dialysis and central line. Review of the care plan indicated that the Resident was on EBP, and the interventions and tasks included: wear gown and gloves during assistance with dressing, bathing, transferring, hygiene, changing linens, changing briefs & toileting, and during dressing change at port. On 07/07/25 at 10:10 AM Resident #288 was observed asleep in bed, with the door slightly ajar. PPE supplies and EBP signage were posted on the door. 07/08/25 at 1:15 PM, there was no EBP sign posted on the door as it was posted on the previous room occupied by Resident #288. 07/08/25 at 3:40 PM another observation was made of Resident #288’s assigned room door which was closed at this time. There was no EBP signage on the door. 3) Review of the record revealed Resident #71 was admitted to the facility on [DATE]. Review of physician orders revealed the resident was placed on contact precautions on 06/28/25 while being treated with intravenous (IV) antibiotics for a Multi-Drug Resistant Organism (MDRO) of the urine. The antibiotic was completed on 07/05/25 and the resident was removed from the contact precautions on 07/08/25 and was placed on Enhanced Barrier Precautions (EBP) related to the presence of a wound. Review of the current care plans documented as of 07/01/25 Resident #71 would be on contact isolation through 07/05/25. A second care plan initiated on 06/17/25 indicated the resident was on EBP related to an open wound, and that gowns and gloves were to be worn during high-contact care activities including linen changes and wound care. During an observation on 07/07/25 at 9:51 AM, a contact precautions sign and PPE was noted on the door of Resident #71. Staff C, Certified Nursing Assistant (CNA), was in the room of Resident #71, pulling down the resident's covers and adjusting the pillow located between her legs. As the CNA was gathering supplies to complete personal care for the resident, she explained she usually worked 11 PM to 7 AM, and that this was her first time on day shift. Staff C, CNA, proceeded to provide personal care for Resident #71, while wearing gloves, but did not don a gown at any time during the care. (continued on next page)

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	105555	A. Building B. Wing	07/10/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/08/25 at 9:16 AM, it was noted Resident #71 had moved to another room and was now on EBP, instead of contact precautions, as per the sign on the door. Staff C, CNA, was in the room, providing personal care to Resident #71 and changing her adult brief. The CNA lacked any gown during this observation. During an interview on 07/08/25 at 10:50 AM, when asked if she knew what EBP and contact precautions meant, Staff C stated, It means I have to wear gloves, gown, and mask when I go into the room for care. When asked why she did not wear a gown during personal care for Resident #71 yesterday, when on contact precautions, or today, when on EBP, the CNA stated, Because I just moved to days, I wasn't sure which resident (referring to A bed or B bed) was on the precautions. When asked what the orange dot next to the name meant, the CNA did not know. During an interview on 07/09/25 at 5:49 PM, when told of the observations of Staff C, CNA, providing care to Resident #71, and the interview with the CNA, the Infection Preventionist (IP) stated the CNA should have been wearing a gown during the care tasks. When asked about the orange dots next to the resident names throughout the facility, the IP explained those dots indicate which of the residents in the room are on the EBP.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations and interview, the facility failed to have an effective pest control program. The findings included: During the initial kitchen tour, on 07/07/25 at 9:11 AM with the Food Service Director/Certified Dietary Manager (CDM), the following were noted: 1. In the hot holding area of the kitchen, two live and mature roaches were observed on a table by the conveyor toaster.2. In the food service area (where staff collect the plates from the cooks and place in the carts to take to the units and the Main Dining Room) live roaches, in all stages of life and too numerous to count were observed behind a cart containing a stack of trays and single service items (sugar packets, condiments, tea bags etc.) At the time of the observation, the CDM instructed staff to remove the cart, dispose of the single service items, clean and sanitized the cart and the trays that were stacked in the cart. On 07/10/25 at 12:35 PM, the Surveyor attempted to contact the pest control company that provided services to the facility and a voice message was left. There was no response from the pest control company.