

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Parkway		STREET ADDRESS, CITY, STATE, ZIP CODE 800 SE Central Pkwy Stuart, FL 34994	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50895</p> <p>Based on observation, interview, and record review, the facility failed to ensure accessibility of the call bell for 1 of 1 sampled resident, Resident #99, observed needing assistance and unable to call staff.</p> <p>The findings included:</p> <p>Review of the record revealed Resident #99 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 8, on a 0 to 15 scale, indicating moderate cognitive impairment. This same MDS documented the resident usually understands and is usually understood and required partial to total assistance from staff for activities of daily living (ADLs). Review of the current resident care plans dated 06/06/24 for Visual impairment, Cognitive Loss/Dementia, ADLs, and Pain, all included the approach: call light within reach.</p> <p>During an observation and interview on 06/03/24 at 12:00 PM, Resident #99 was observed sitting in his wheelchair close to the footboard area of the bed with his meal tray in front of him. When asked why he wasn't eating his food, Resident #99 said he didn't like the entree that was served. When asked if he was aware whether other food options were available, he replied he was not aware that food options were available. When asked if he may want to use the call bell to request another food option, the resident answered, I don't know where it is.</p> <p>At this time, the call bell was clipped to the upper corner of the bed close to the headboard and the red button was dangling down approximately 2-3 inches from the corner of the bed. Photographic Evidence Obtained.</p> <p>When asked if he could move himself in the wheelchair towards that location, the resident said he doesn't really move around the room in his wheelchair. When placed in front of the resident, Resident #99 pressed the call button. A nurse entered the room and Resident #99 requested a grilled cheese sandwich for lunch.</p> <p>An observation on 06/04/24 at 10:17 AM revealed Resident #99 in bed with the call bell cord clipped to the upper corner of the bed. The call bell was located on the bedding next to the right side of the resident's ribcage. An interview with Resident #99 revealed he did not know where the call bell button was. When told the location of the call bell button and prompted to try and reach it, Resident #99 was unable to navigate his hand to touch the call bell.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Parkway		STREET ADDRESS, CITY, STATE, ZIP CODE 800 SE Central Pkwy Stuart, FL 34994	
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/05/24 at 9:30 AM, Resident #99 was observed in bed. The call bell cord was clipped to the left top corner of bed. When asked if he could reach the call bell, the Resident answered No. Resident #99 was observed trying to drink juice and having difficulty drawing fluid up through the straw. The resident removed the straw from the cup and looked at it. The straw did not have a hole on the bottom where the juice should flow through. The straw appeared squeezed closed on the bottom. The surveyor placed the call bell button within sight of resident. Resident #99 pressed the button, and a nurse entered the room. She saw the problem with the straw and brought the resident a new straw. The resident drank the juice effectively with the new straw. Resident #99 demonstrated understanding of the usefulness of pressing the call button for assistance, and he demonstrated the ability to press the call bell button.</p> <p>On 06/06/24 at 12:17 PM, Staff D, 100-200 Unit Manager, was informed of the three observations made of Resident #99's difficulties accessing and using the call bell button. Staff D acknowledged the finding and stated they would need to devise a plan to provide access to the call bell.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Parkway		STREET ADDRESS, CITY, STATE, ZIP CODE 800 SE Central Pkwy Stuart, FL 34994	
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404</p> <p>Based on observation, record review, interview, and policy review, the facility failed to ensure the anchoring of indwelling urinary catheter tubing for 2 of 3 sampled residents, one of whom had a history of urinary tract infections (UTIs), Residents #34 and #204.</p> <p>The findings included:</p> <p>Review of the policy, titled, Catheter Care, Urinary, revised 01/25/23, documented, in part, Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Changing Catheters . 2. Ensure that the catheter remains secured to reduce friction and movement at the insertion site. (Note: Catheter tubing should be secured to the resident's inner thigh.)</p> <p>1. Review of the record revealed Resident #34 was admitted to the facility on [DATE], with readmission on 05/28/24. Record review revealed a diagnosis of urinary retention with the placement of an indwelling urinary catheter. The physician order dated 05/29/24 documented to secure the indwelling urinary catheter with a leg strap. The current order dated 05/01/24 documented the use of an indwelling catheter for Resident #34. One of the care plan approaches included utilizing a catheter holder to prevent pulling.</p> <p>An observation was made on 06/05/24 at 9:42 AM with Staff A, Certified Nursing Assistant (CNA). Resident #34 was lying in bed, and the indwelling urinary catheter was noted taunt, coming out of the bottom of the adult brief. There was no type of anchoring device for the catheter tubing. Staff A provided personal care, not mentioning the lack of the anchoring device.</p> <p>During an interview on 06/05/24 at 2:58 PM, when asked if she knew about the missing anchor, Staff D, 100-200 Unit Manager, stated she had not been informed. A subsequent observation at this time, with Staff D and the Assistant Director of Nursing (ADON) revealed Resident #34 still did not have any anchoring device for the indwelling urinary catheter tubing. The tubing was again pulled tautly coming from the bottom of the adult brief.</p> <p>2. Review of the record revealed Resident #204 was admitted to the facility on [DATE]. Admission diagnoses included retention of urine and urinary tract infection (UTI). Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] documented Resident #204 had a Brief Interview for Mental Status (BIMS) score of 12, on a 0 to 15 scaled, indicating the resident had minimal cognitive impairment. This MDS also documented the resident had an indwelling urinary catheter with a diagnosis of Obstructive Uropathy (inability to urinate because of an obstruction).</p> <p>Review of a current order, dated 05/21/24, documented the indwelling urinary catheter was to be secured with a leg strap. The current care plan dated 05/21/24 documented the resident had a recent UTI and included utilizing a catheter holder to prevent pulling.</p> <p>An observation on 06/03/24 at 2:39 PM revealed Resident #204 lying in bed. A urinary catheter leg bag was noted with no type of anchoring or securing device. The tube was noted towards the back of his leg.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Parkway		STREET ADDRESS, CITY, STATE, ZIP CODE 800 SE Central Pkwy Stuart, FL 34994	
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 06/05/24 at 8:33 AM, Resident #204 was sitting up in his wheelchair. The urinary catheter leg bag was noted. When asked if he had any type of catheter strap or anchor, the resident pulled up the leg of his pants and there was no anchor.</p> <p>During a subsequent observation with the ADON on 06/05/24 at 3:03 PM, a thigh strap was noted to secure the urinary catheter tubing. Resident #204 stated staff had just put it on.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Parkway		STREET ADDRESS, CITY, STATE, ZIP CODE 800 SE Central Pkwy Stuart, FL 34994	
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 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>25404</p> <p>Based on observation, record review, interview, and policy review, the facility failed to ensure competent nurse staff for 2 of 7 sampled residents observed during the medication administration observation. Staff C, Licensed Practical Nurse (LPN), failed to follow the facility's process related to the administration and documentation of insulin for Resident #49; and Staff B, Licensed Practical Nurse failed to use proper technique during a nasal spray administration for Resident #74.</p> <p>The findings included:</p> <p>1. A medication administration observation for Resident #49 was made with Staff C, LPN, on 06/04/24 beginning at 4:59 PM. Staff C prepared oral medications that were due at that time, along with an insulin pen stating the resident had 7 units due at that time and headed for the resident's room. At the entrance to the room, the surveyor stopped the LPN from entering the room, and asked the LPN the type of insulin she had for Resident #49. At this time the LPN stated Novolin R (regular insulin), showing the label to the surveyor. The LPN obtained the blood sugar level for Resident #49, then dialed 7 units of insulin on the pen and showed it to the surveyor. The LPN administered the insulin into the resident's left arm.</p> <p>Review of the Medication Administration Record (MAR) for Resident #49 revealed the order dated 12/19/23 for the 7 units of Novolin R insulin, to be administered via the FlexPen. Staff C had signed off the administration of the 7 units of Novolin R, and further documented she had verified the dose before the administration but entering the initials of another person.</p> <p>During an interview on 06/04/24 at 5:51 PM, when asked the process for the administration of insulin to a resident, specifically asking about the insulin dosage, Staff C described the process of checking the resident's blood sugar level and administering the insulin. The LPN did not describe the second nurse verification step. When asked about the 2nd Nurse Verify Before documentation on the MAR, the LPN confirmed their process was to have a second nurse verify the dose, further stating, Because you are a nurse I verified with you. When asked whose initials she documented on the MAR, the LPN stated they were the initials of the other nurse working that shift. When asked why she documented the other nurse's initials, when she did not verify the dose with any other facility nurse, the LPN again stated she verified the dose with the surveyor, but wrote the initials of the other nurse, as they always verify for each other. When asked again if she verified the 7 units with the other nurse whose initials were documented in the MAR, the LPN stated she did not, but again stated she had verified with the surveyor.</p> <p>On 06/05/24 at 2:54 PM, the Director of Nursing (DON) was informed of the insulin administration by Staff C for Resident #49. The DON confirmed they did have a second nurse verify process for insulin administration, and agreed Staff C should not have verified with a non-employee, nor should she have put the initials of the other staff in the MAR when she did not verify with that second staff. The DON was asked to provide their written process for the second nurse verify of insulin. The DON later stated they did not have the second nurse verification as a written process, but again stated it was part of the facility protocols.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Parkway		STREET ADDRESS, CITY, STATE, ZIP CODE 800 SE Central Pkwy Stuart, FL 34994	

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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the policy, titled, Nasal Administration, revised January 2018, documented, in part, Procedure: . H. Use finger of other hand to close the nostril that is not receiving medication by gently pressing the side of the nostril. This policy then described the administration of the nasal spray followed by illustrations of how to occlude the opposite nasal cavity.</p> <p>A medication administration observation was made for Resident #74 on 06/04/24 at 4:38 PM. Staff B, LPN, obtained medications for the resident to include a Deep Sea nasal spray of 0.65% saline solution. The LPN administered two sprays into each nasal cavity but failed to occlude the opposite nasal cavity during the administration.</p> <p>Upon request of the policy on 06/05/24 in the afternoon, the Risk Manager was made aware of the medication administration observation for Resident #74.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Parkway		STREET ADDRESS, CITY, STATE, ZIP CODE 800 SE Central Pkwy Stuart, FL 34994	
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 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404</p> <p>Based on record review, interview, and policy review, the facility failed to implement pharmacy recommendations approved by the physician for 1 of 5 sampled residents, Resident #38.</p> <p>The findings included:</p> <p>Review of the policy, titled, Medication Regimen Review, revised January 2018, documented, in part, Procedure: . G. Recommendations are acted upon and documented by the facility staff and/or the prescriber.</p> <p>Review of the record revealed Resident #38 was admitted to the facility on [DATE]. Review of the current orders revealed the order initiated on 05/31/23 for the anti-reflux medication, Protonix 40 milligrams (mg), ordered daily for Anemia.</p> <p>Review of the monthly pharmacy reviews revealed on 12/17/23 the pharmacist identified Resident #38 had been on the anti-reflux medication Protonix 40 mg daily for more than 12 weeks, and recommended the medication be discontinued. This recommendation also documented the need for appropriate documentation supporting an underlying chronic disease if continued. On 01/03/24, the physician agreed but documented to decrease the Protonix to 20 mg daily. Review of the subsequent monthly reviews for January 2024 through May 2024 lacked any recommendations related to the Protonix.</p> <p>Review of the current order (05/31/23) and the Medication Administration Record (MAR) documented the resident was still being administered Protonix 40 mg for a diagnosis of Anemia.</p> <p>During a side-by-side record review and interview on 06/06/24 at 11:34 AM, Staff D, the 100-200 Unit Manager, was asked the process for the monthly pharmacy reviews. The Unit Manager explained the pharmacist does the monthly reviews and provided them to the Director of Nursing, who then prints them out and provides them to each Unit Manager. The Unit Managers then speak with the physician either in person or via call, reviews the recommendations, and then the physician will sign them upon his next visit if applicable. The Unit Manager then is responsible for entering the new orders into the electronic medical records. The Unit Manager was shown the recommendation for Resident #38 regarding the Protonix and was unsure as to how or why it was not decreased as per the physician's signature and request.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Parkway		STREET ADDRESS, CITY, STATE, ZIP CODE 800 SE Central Pkwy Stuart, FL 34994	

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 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>50895</p> <p>Based on observation and policy review, the facility failed to prepare pureed food with the correct texture. This had the potential to affect 16 of 165 current residents who had a physician ordered pureed diet.</p> <p>The findings included:</p> <p>Review of the facility's written description of the pureed diet, reprinted from the Manual of Medical Nutrition Therapy 2022, documented, The pureed diet is designed to provide soft, smooth foods that minimize the amount of chewing required and are easy to swallow. Any regular or therapeutic diet may be pureed. The pureed diet is indicated for individuals with chewing or swallowing problems.</p> <p>On 06/05/24 at 11:50 AM, observations in the kitchen revealed the pureed diet Italian Parmesan Breaded Pork and the pureed Parslied Noodles did not look smooth. At this time, a sample of the pureed food prepared for the lunch meal was requested. Upon tasting the food, the pureed pork had chopped up strings in it and the pureed pasta had lumps.</p> <p>At this time, when asked about the process for ensuring the correct texture of the pureed foods, the Director of Food Services (DFS) stated she usually tastes it but did not do so that day. The DFS was asked to taste the pureed foods. The DFS did not collaborate with the findings of stringy pork or lumpy pasta, but stated she would puree those foods again.</p> <p>An observation of the pureed foods served in the main dining room on 06/05/24 at approximately 1:00 PM revealed a smoother texture.</p>