

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105762	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Prosper Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11375 Prosperity Farms Road Palm Beach Gardens, FL 33410	

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 proper care and services for the indwelling urinary catheters for 2 of 3 sampled residents, related to improper catheter care for Resident #1, and failure to properly anchor the indwelling urinary catheters for Residents #1 and #67, for the prevention of urinary tract infections (UTIs).</p> <p>The findings included:</p> <p>Review of the Indwelling Urinary Catheter Care Competency, (not dated), documented, in part, 11. Hold catheter near meatus (insertion site) to prevent pulling when handling and cleanse catheter using clean area of washcloth, washing away from the body and down the catheter at least 3 - 4 inches.</p> <p>Review of the Indwelling Urinary Catheter Insertion/Removal Competency, (not dated), documented, in part, 20. Anchor catheter (thigh if appropriate and coil tubing on bed and attach to mattress).</p> <p>1. Review of the record revealed Resident #1 was admitted to the facility on [DATE]. Review of the current care plan initiated on 03/26/24, documented the resident was on an antibiotic for a Urinary Tract Infection (UTI). An observation on 05/03/24 at 9:13 AM revealed Resident #1 in bed, with a urinary catheter bag to bedside drainage. The urine in the tubing was very dark and cloudy. Photographic Evidence Obtained</p> <p>An observation of care to the indwelling urinary catheter was made on 05/03/24 at 10:49 AM. Resident #1 had an anchor attached to his thigh, but the catheter tubing was not secured in the anchor. Staff B, Certified Nursing Assistant (CNA), first provided personal care and changed the water basin. The CNA then held the catheter tubing about 8 to 10 inches away from the insertion site, wiping the tubing from the insertion site outward, pulling on the catheter during cleansing. Some visible brown debris was removed from the outside of the catheter tubing as the white washcloth was noted with brown debris. While cleansing the catheter tubing, the tubing that was pulled outward, had a ring of brown debris at the insertion site, that was not cleansed by the CNA. The catheter tubing remained out of the anchor throughout the care and the tubing was pulled taunt during care and while turning the resident from side to side. The CNA applied an adult brief, covered the resident, and went to the resident's bathroom to wash her hands. The CNA confirmed she was done with care. The CNA had not attempted to put the tubing into the anchor and the tubing remained taunt.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 105762
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/03//24 at 2:44 PM, Staff C, Licensed Practical Nurse (LPN) stated she looked at the catheter this morning during rounds. When asked how the catheter was this morning, the nurse stated it was fine. When asked if she looked at the tubing, she said it was ok. The nurse was unaware of the cloudy urine or the lack of an attached catheter anchor.</p> <p>During an observation and interview on 05/03/24 at approximately 3:00 PM, the Director of Nursing (DON) agreed with the failure to utilize the anchor and that the urine was cloudy and should have been identified and acted upon by the direct care nurse, Staff C.</p> <p>39167</p> <p>2. Record review revealed Resident #67 was admitted to the facility on [DATE] with recent readmission on 04/24/24, with a diagnosis to include End Stage Renal Disease (ESRD). The Minimum Data Set (MDS) assessment, reference date 03/03/24, recorded a Brief Interview for Mental Status (BIMS) score of 06, indicating Resident #67 was moderately cognitively impaired.</p> <p>Clinical record review showed, Resident #67 had a history of UTI (urinary tract infection), as evidenced by antibiotic administration, which started on 09/10/23, of ciprofloxacin 500 mg for 5 Days for UTI. In addition, Resident #67 had an indwelling catheter in place related to a Stage 3 wound of the sacrococcygeal area.</p> <p>On 05/03/24 at 12:38 PM, perineal / catheter care observation was started. The care was being conducted by Staff A, CNA. During the care, it was observed that the anchor to the catheter was not adhered to the resident's skin, to secure and prevent it from being pulled and moving. After the completion of the perineal / catheter care, at 12:43 PM, wound care was commenced by Staff B, Wound Care Nurse. During the wound care, as the staff turned and moved the resident in the bed, the catheter was being pulled, due to it not being secured and adhered with an anchor. When the surveyor pointed to the unattached anchor and brought it to the attention of Staff A and Staff B, Staff A voiced she was going to inform the attending nurse, Staff D, LPN, to apply a new one. Approximately 30 minutes later, a subsequent observation revealed the anchor of the catheter had not been replaced.</p>		