STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105762	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prosper Health and Rehabilitation Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 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 record review, interview and policy review, it was determined, the facility failed to report an allegation of abuse. The failure affected 1 of 2 sampled residents, Resident #1.The findings included: Review of the facility policy titled Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI), last revised 03/2025, documents Reporting: Allegations of possible ANEMMI will be reported to state agencies per federal regulation time frame. State agencies may include, Abuse Hotline, State Agencies and Local Law Enforcement.Initial reporting: allegations are reported immediately, but no later than two hours .within five working days of the incident, the facility must provide in its report, sufficient information to describe the results of the investigation and indicate any corrective actions taken. Clinical record review revealed Resident #1 was admitted to the facility on [DATE] for rehabilitation services. Review of the Minimum Data Set admission (MDS) assessment with reference date of 03/13/25 documented the resident was assessed as independent with skills for daily decision making and had no behaviors. The clinical record documented Resident #1 was transferred to the emergency department on 03/30/25, as per the resident request. The clinical record documented Resident #1 was transferred to the emergency department on 03/30/25, as per the resident request. The resident had called 911 alleging the aide hit him over the head, the police and EMS came and the police verified there was no hitting on the video the resident presented. The resident was then taken to the hospital for evaluation. The resident returned the same day, as this is where he was residing at the time.On 07/01/25 at 12:54 PM, the Administrator (NHA) stated that another State Government Agency did not take the case when they called it in, but that then on 04/04/25, the representative showed up to investigate the allegation of abuse for 03/30/25. On 04/04/25, the resident was discharged home, had gone back to the hospital and then to another nursing home facility. Review of the Grievance log documents Resident #1 filed a grievance on 03/31/25, noting the resident states the aide came in the room more than one time to harass him. Review of the Social Worker Assistant note documented the following on the form titled, Resident Interview and Questionnaire Related to Abuse dated 03/31/25 documents as follows:Did you report the alleged abuse? Response, NO.Ask why didn't you report it to the nurse? Response, I called the person that came to mind,Did you report the alleged abuse to any external entities? Response, call 911 and fire rescue arrived. Review of the Police report dated 04/02/25 documents Made contact with Administrator who stated that one of her patients informed her that on 03/30/25, he got hit on the head by a nurse and that she was contacting [another State Government Agency]. The interview with the Administrator conducted on 07/01/25 at 12:54 PM also revealed Resident #1 never reported the allegation of abuse to her. The police came to the facility and reviewed the resident's phone video and determined there was no abuse. The administrator confirmed she contacted [another State Government Agency] for the incident and did not complete the required reporting to the regulatory agency, because she did not feel it met the criteria for abuse. The Administrator stated after the fact and researching the hospital records, she was made aware of the open [another State Government Agency] case alleging the resident was neglected at home, involving one of his family members. An interview with the [another State Government Agency] Investigator conducted on 07/01/25 at 2:37 PM confirmed he was at the facility on 04/04/25 to investigate an allegation of physical abuse for Resident #1. The investigation determined the facility failed to report the allegation of abuse to the regulatory agency.

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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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 0627 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 record review and interview, it was determined, the facility failed to ensure discharge planning was implemented in a safe manner. The failure affected 1 of 2 sampled residents, Resident #1.The findings included:Clinical record review conducted on 07/01/25 revealed Resident #1 was admitted to the facility on [DATE] with diagnosis of Hemiplegia, Dysphagia, Diabetes, Stroke, and status post Coronary Artery Bypass Graft and Craniotomy.The clinical record documented Resident #1 was transferred to the emergency department on 03/30/25, as per the resident request. The resident had called 911 alleging the aide hit him over the head, the police and EMS (Emergency Medical Services) came, and the police verified there was no hitting on the video the resident presented to them. The resident was then taken to the hospital for evaluation. The resident returned the same day, as this is where he was residing at the time.On 07/01/25 at 12:54 PM, the Administrator (NHA) stated that [another State Government Agency] did not take the case when they called it in, but that on 04/04/25, the representative showed up to investigate the allegation of abuse for 03/30/25.On 04/04/25, the resident was discharged home, had gone back to the hospital that same day (04/04/25), then went to another nursing home facility, and is currently residing at home with family. Review of the Minimum Data Set (MDS) Discharge Assessment, with reference date of 04/04/25, documented the resident required partial to moderate assistance with bathing and dressing, was dependent with transfers and used a manual wheelchair for mobility. The resident was frequently incontinent of bladder and always incontinent of bowel and had an active discharge plan to return to the community. Review of the record documented the resident was alert and oriented to person, place, others, and time. Review of the Physician/Practitioner Progress Notes for service date of 04/02/25 documented: CHIEF COMPLAINT: Need for Assistance with Mobility and ADL's (Activity of Daily Living) secondary to recent caregiver neglect and pneumonia, now with medical debility.PAST MEDICAL HISTORY:CHF (Congestive Heart Failure), CAD (Coronary Artery Disease) with CABG (Coronary Artery Bypass Graft) X 2, HTN (Hypertension) and Brief Psychotic Disorder.HOSPITAL COURSE: . presented to the hospital on [DATE] with heart failure and was admitted to the ICU for Surgical Optimization for planned mitral valve replacement. Post Operative course was complicated by Acute Stroke with subsequent Hemorrhagic conversion, mitral valve thrombus, required emergency decompression craniotomy 2 days later. After rehabilitation, the resident had a readmission to the acute care hospital on 2/17/25 for complaints of caretaker abuse and neglect. Prior Level of Function: Per Family: Patient lived alone and was independent of all ADLs. Current Level of Function per therapists, the resident requires maximal assistance for bed mobility; dependent for transfers and ambulation. Review of the Social Service Notes dated 04/02/25 documented, Met with resident and spoke with [family member-X] via phone to discuss details of requested discharge on [DATE]. Family member requested I speak with [family member-Y]. Detailed message left requesting return phone call. Referral faxed to home health agency for nursing, therapy and home health aide. Referral faxed for a hemi-walker. Family to provide transport. Review of the Social Service Notes dated 04/04/25 documented, Resident did not discharge on [DATE] as his [family member-X] had his house keys and was not responding to phone calls. The [family member] came by today and dropped off the house key. I inquired if she would be at the house, she stated the other [family member] handles that. Spoke with the veteran's home health and they arranged for 30-35 hours per week, per resident request to advise discharge is for today and resident would like to resume services. [Family member] agreed she would check on him but is not available 24/7. Transportation arranged with [company] transport. A message left for [family member] advising her transportation will pick him up between 4:30 to 5 PM, requesting she be at the house. Resident advised. Review of the Discharge Planning/Summary Notes dated 04/04/25 documented, Resident is alert and oriented. Discharge instructions given by writer resident verbalized understanding. Resident left facility with [company] transport, all personal belongings in resident's possession confirmed. Resident escorted out of building via wheelchair by staff and transporter. All safety measures met. Review of the Home Health documentation revealed they were unable to reach the resident or family members on 04/03/25, 04/04/25 and 04/07/25. The facility staff wrote on 04/10/25 that the home health agency would not take Resident #1' s case due to high liability and the facility staff questioned why they did not notify the facility. An interview with the Social Worker (SW) conducted on 07/01/25 at 12:04 PM revealed that upon discharge, Resident #1 already had services set up from the veteran's association, in addition she set up home health services for therapy and nursing follow up. The