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	06/16/2026

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 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, clinical and administrative record review and interview, the facility failed to ensure that residents received the necessary care and services for wound care. This is evidenced by the staff failure to provide evidence of thorough assessment when a wound is noted as open; failed to complete the weekly skin checks appropriately; failed to correctly identify skin issues in a timely manner; and failed to ensure wound care is done as prescribed and dated appropriately. This failure affected 2 of 3 sampled residents reviewed for wound care, Resident #1 and Resident #2. The findings included:1. Record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses which included Parkinson Disease, immunodeficiency, muscle atrophy, dementia and history of cerebral infarction. The resident requires total assistance with his activities of daily living and is incontinent of bowel and bladder. An observation of the wound care on Resident #2 was conducted on 06/16/26 at 10:25 AM with the Wound Care Nurse and the Certified Nursing Assistant (CNA), Staff A. The nurse revealed the wound dressing noted on the resident's buttock. The wound dressing was dated 06/12/26 and had the wound care nurses' initials on it. The WCN confirmed that the date on the dressing was 06/12/26 (4 days ago). The resident was apparently sleeping soundly during this observation, and he did not respond throughout the wound care observation. Review of the physician order revealed that on 05/01/26, the physician prescribed Sacrum: Cleanse with NSS (normal saline solution) or wound cleanser, pat dry, apply collagen sheet and calcium alginate, cover with silicone border dressing. every day shift for pressure wound. Additionally, a later review of Treatment Administration Record (TAR) revealed documentation for the above wound care. Further review of the TAR revealed the wound care nurse's initials were noted on 06/12/26 and 06/16/26, indicating the dates she performed the dressing change. The other dates of 06/13/26, 06/14/26 and 06/15/26 had other nurses' initials noted on the TAR. The 06/02/26 wound care physician progress note documented the resident has a Stage 4 pressure injury since 01/30/26 currently measuring 1.8 cm x 0.8 cm x 0.5 cm with undermining of 0.6 cm from 10-2'o'clock. Wound with small amount of serous exudate, 80% granulation and 20 % slough. On 06/02/26, the physician provided additional clinical recommendations as follows:Offload WoundTurn and reposition per facility protocoloffload heels with pillowsheel bootsDietary evaluationConsider skin substitute for wound closure.Observations of the resident on 06/16/26 at 10:25 AM and 3:25 PM revealed the resident was wearing non-skid socks and the resident feet were resting directly on the mattress. The resident's feet were not offloaded, and he was not wearing offloading heel boots. The resident remained in bed on this date and again the resident was apparently sleeping and did not respond during the observations.An interview was conducted with Staff A, CNA, during the 3:25 PM observation. Staff A confirmed the resident's feet were not offloaded, and he did not have the boots.An interview was conducted on 06/16/26 at 3:38 PM with the Licensed Practical Nurse, Staff B, who was assigned to the resident for the 7AM-3PM shift. At this time Staff B had been observed giving report to the oncoming nurse and she was preparing to leave for the day. The surveyor asked Staff B regarding the care needs for Resident #2. She stated she had to look it up. The surveyor inquired regarding the preventative care the resident was to have and if she was aware the resident was receiving the care (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that he was prescribed. She too was not aware that the resident was to have his heels offloaded and she confirmed the resident was in bed this date. 2. Record review revealed Resident # 1 was admitted to the facility on [DATE] with diagnoses which included Metabolic Encephalopathy, Muscle Weakness Muscle Wasting and Atrophy, Dementia, and Dysphagia. The initial nursing assessment documented the resident had a right lower leg (front) skin tear. A weekly skin check was done on 02/24/26 (second skin check) which was noted to document indicate below skin injuries / ulcers such as pressure ulcers, venous insufficiency/ischemia ulcers (i.e., Venous stasis and arterial ischemic ulcers), diabetic neuropathic ulcers, bruises, abrasions, lacerations and abnormal skin discoloration by marking the body. Comment on color, moisture, temperature, integrity and/or turgor as appropriate. The 02/24/26 note noted the following: Right anterior lower leg: skin tearAbdomen, peg tubeSacrum, healed Stage 4 woundLeft ischium, healed Stage 4 woundBilateral lower extremities gangrene. The subsequent weekly skin checks beginning on 02/28/26, 03/07/26, 03/14/26 and 03/17/26 noted an open area to the lower right leg. There was no further description of the open area identified on the resident's right lower leg nor were there any treatment orders for this area. There was no documentation of a right heel injury until 03/21/26 (when the right heel is noted as stable eschar) or left anterior lower leg injury noted. These two additional areas were documented in March, by the wound care physician. The order for a wound care consult was prescribed on 03/19/26 for the right heel. The initial Wound Care physician's progress notes on 03/23/26 documented for: Site 1 right heel wound measuring 2.5 x 5.0 x 0.0, black necrosis (eschar) 100%; Site 2 - right anterior lower leg (the area that has been documented as open since 02/28/26 without specific documentation identifying the wound). The physician documented the right lower leg anterior measuring 4.5 cm x 4.0 x 0.1 cm, moderate amount of serous drainage. On 02/23/26, the physician prescribed Wound Care-Skin Prep: May apply skin prep to bilateral heels every Shift x14 days and it was discontinued on 03/09/26. There were no further orders noted for the right heel until the physician prescribed wound care on 03/19/26 and 03/23/26. There was nothing documented on the weekly skin checks regarding the heel until after the Wound Care physician involvement. An interview was conducted on 06/16/26 at approximately 11:30 AM with the Wound Care Nurse (WCN). After finally receiving the wound care list from February to present, the surveyor reviewed it with the WCN, why Resident #1 was not identified on the wound care list until April 7, 2026. She had no explanation to this oversight. The surveyor inquired of the reason that there was no description of the open area noted on the weekly skin checks for the right lower leg anterior beginning 02/28/26. The WCN only stated that we can't stage wounds. The surveyor questioned that there was no documentation of the resident having any concerns on his heels until the wound care physician was consulted on 03/19/26 and assessed by the wound care physician on 03/23/26 and noted an eschar. The WCN then stated she didn't know because the resident's heels were red and that's why they were applying skin prep. The surveyor expressed this was not documented or identified on the weekly skin checks nor was the resident identified on the wound list. A telephone interview was conducted with the Wound Care Physician on 06/16/26 at 1:15 PM, who expressed that the resident has severe advanced Peripheral Vascular Disease and he doesn't take care of skin tears. He confirmed he did not get involved with the resident's wound care until March 23, 2026, and further stated he could not attest to anything prior, but it may have been a skin tear with advanced PVD [peripheral vascular disease]. The surveyor said that the staff initially documented the area as a skin tear but later documented that the wound was opened but did not provide any further details regarding the wound. The surveyor stated that the staff did not identify any concerns regarding the resident's heel until the order to consult Wound Care and then the right heel was documented as eschar.