

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 04/04/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404</p> <p>Based on observation, interview, and record review, the facility failed to ensure the provision of mechanical lift slings (used for the Hoyer lifts) for 7 of 12 sampled residents who require a mechanical lift for transferring (Residents #1, #18, #19, #44, #67, #89, and #100). Three of 12 sampled residents had a lift sling, but there was no name on the sling to identify it to the resident, as per the facility process (Resident #20, #23, #63). Eleven of 13 random non-sampled residents either did not have a lift sling, had one with no name on it, or had one belonging to another resident. At the time of the survey there were 24 residents who were assessed as needing the mechanical lift for transferring.</p> <p>The facility also failed to provide a wheelchair for 1 of 1 sampled resident (Resident #89), and failed to ensure proper bed and or mattress for 2 of 2 sampled residents (Residents #98 and #260).</p> <p>The findings included:</p> <p>1) On 04/04/24 at 2:00 PM when asked for a policy for mechanical lift transfers, the regional consultant stated the facility did not have one.</p> <p>Review of the record revealed Resident #89 was admitted to the facility on [DATE] and had resided on the 200 pod the entire time. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident was totally dependent on staff for transferring. Review of the current care plan initiated on 01/02/24 documented Resident #89 had a self-care deficit and used a mechanical lift for transfers.</p> <p>During an interview on 04/01/24 at 11:40 AM, the son of Resident #89 stated yesterday was the first time in 21 days that his mother had been up out of bed. When asked why, the son explained the staff can never find a lift sling, and they had finally gotten another one yesterday. The son stated they had brought in their own sling and it was now lost. The son explained that either he or his sister are with their mother 24 hours a day, explaining they sleep on a recliner chair.</p> <p>During an interview on 04/01/24 at 5:09 PM, the daughter of Resident #89 stated she was told to bring in her mother's own wheelchair as they were running low on them. An observation at that time revealed her personal blue wheelchair, similar to a facility companion chair. Facility wheelchairs were black.</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: 105762	Facility ID: 105762 If continuation sheet Page 1 of 28

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a supplemental interview on 04/03/24 at 10:44 AM, the daughter volunteered staff were always having trouble finding the mechanical lift slings to transfer her mother out of the bed and into her wheelchair. The daughter stated she brought her own lift sling in, and it was now lost, showed the surveyor that the current lift sling in the room that had the name of Resident #19 hand written on the label (Photographic Evidence Obtained). The last lift sling the staff had for her mother belonged to a resident on the 300 pod. The daughter stated she thought maybe the resident from the 300 pod had been discharged , but she walked over to that unit, and the resident was still at the facility.</p> <p>On 04/03/24 at 11:01 AM, Staff F, Personal Care Attendant (PCA) returned the personal mechanical lift sling to Resident #89. The PCA stated he found it in a plastic bag, noted the name of Resident #89 on the sling, and so he returned it.</p> <p>During an interview on 04/03/24 at 12:04 PM, Resident #19, who resided on the 600 pod, stated he did not have his lift sling. The resident stated he was upset as staff had not been able to get him up all week because his lift sling was missing. Resident #19 stated it was sent to the laundry on Friday and he hadn't seen it since. The resident became upset, and stated he had a medical appointment in two days, and the facility better find it.</p> <p>During an interview on 04/03/24 at 12:15 PM, the Nursing Home Administrator (NHA) was made aware that the lift sling belonging to Resident #19 was found by the surveyor, in the room of Resident #89. The NHA stated she was made aware of the missing lift sling the previous day. The NHA stated every resident who was transferred via the mechanical lift should have their own lift sling with their name on it. The NHA went to the room of Resident #89 to get the lift pad for Resident #19, so she could take it to laundry. The daughter of Resident #89 was in the room and stated her mother had never had a lift sling from the facility, designated for her mother. The NHA stated she was unaware the daughter had brought in her own lift sling.</p> <p>On 04/03/24 at 12:20 PM, the Central Supply staff was observed with a lift sling and wrote the name of Resident #89 on the label. The Central Supply staff stated she only had one more sling available at that time, but had ordered four the previous week.</p> <p>On 04/03/24 beginning at 3:40 PM interviews and observations with the Unit Manager, were completed for the 24 residents who were identified as needing a mechanical lift for transfers. With permission from each resident, observations were made in search of the mechanical lift slings. The following was identified for the sampled residents:</p> <p>a) Resident #20 had a mechanical lift sling in her dresser drawer without a name on it, but the resident stated that was not the one that staff used for her transfers. The resident had no idea where staff were obtaining the sling for her use.</p> <p>b) Resident #23 had a lift sling in a dresser drawer that did not have a name on it.</p> <p>c) Resident #63 had a lift sling with no name.</p> <p>d) No lift sling was found for Resident #67.</p> <p>e) No lift sling was found for Resident #44.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>f) The lift sling for Resident #19 had been found earlier by the surveyor in the room of Resident #89.</p> <p>g) No lift sling was found for Resident #1.</p> <p>h) No lift sling was found for Resident #18.</p> <p>i) Resident #100 had the lift sling for Resident #67.</p> <p>Eleven of 13 additional random non-sampled residents either did not have a lift sling, had one with no name on it as per facility stated process, or had one belonging to another resident.</p> <p>During these observations, the Unit Manager agreed each resident who was assessed as needing a mechanical lift sling, should have one. The Unit Manager agreed with the above findings.</p> <p>32078</p> <p>On 04/04/24 at 10:10 AM, the staff responsible for Central Supply stated, I order supplies once a week, and when I see we are running low on something, I will put an order in. I just put in an order for 38 Hoyer lift slings yesterday. When asked how many slings are currently in Central Supply, she stated, I have only 1 sling here in Central Supply right now. There are also some out in the residents' rooms. This staff member was unable to state when the slings were due for arrival. She stated, I would have to contact the corporate office to get tracking information for the delivery date.</p> <p>38893</p> <p>3). Resident #260 was admitted to the facility on [DATE]. According to the resident's most recent full assessment, an Admission Readmission Nursing Evaluation, dated 03/27/24, Resident #260 was alert, easily arousable and oriented to person place time situation.</p> <p>During an interview, on 04/01/24 at 11:01 AM, with Resident #260, Resident #260 stated that the bed was not inflating properly on the resident's right side. Resident #260 stated that she had been laying like that in the bed since admission. The mattress was observed to be deflated on the resident's right side.</p> <p>During an interview, on 04/01/24 at 11:10 AM, with Staff A, CNA, when asked about the bed that Resident #260 was provided, Staff A replied, she has been in that bed since at least yesterday (03/31/24). We didn't have any Maintenance on Sunday to address the bed. I came in yesterday and the bed was like that.</p> <p>During an interview, on 04/01/24 at 11:20 AM, with the Director of Environmental Services, when the concern was brought to his attention, the Director of Environmental Services stated, she was on a regular bed and she was rolling out and we got her a bed with bolsters and we changed it out on Saturday and she sleeps on the side that is lower at the edge. They tried to get her to sleep in the middle. We have to check Central Supply to get her a wider bed. They just told me about it on Saturday. My assistant was here yesterday.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview, on 04/03/24 at 11:03 AM, with Staff E, Maintenance Assistant, when asked about the resident's bed, Staff E replied, Her bed was like that on Friday and I wasn't made aware of it until Saturday. It was already going, and she leaned to the right. Friday I left at 4:30 and didn't know anything about it until Saturday. They said that she was leaning on one side of the bed. I went to the room and seen what was going on with the bed to see if I could fix the situation. She was leaning to the right. That is an air mattress, when you use the dermaflow mattress it is designed to keep the resident in the center of the mattress so that they don't fall, it prevents them from rolling off of the bed. It looked like it was deflated, she was leaning to one side. She told one of the CNAs and the CNA brought it to my attention while I was over there.</p> <p>4). Resident #98 was admitted to the facility on [DATE]. According to the resident's most recent full assessment, an Admission MDS, dated [DATE], Resident #98 had a BIMS score of 08. The MDS documented that Resident #98's height was 68 inches (5 feet 8 inches tall).</p> <p>A Patient Transfer form from the Hospital, dated 01/11/24, documented that Resident #98 was 6 feet 5 inches tall (77 inches).</p> <p>An Admission Nursing Evaluation dated 01/11/24 (upon admission to the facility) documented that the resident was 68 inches tall.</p> <p>A Nutrition Evaluation dated 01/18/24 documented that Resident #98 was 68 inches tall.</p> <p>During an interview with Resident #98, on 04/03/24 at 9:07 AM, Resident #98 was in bed with the head of his bed raised and breakfast on the resident's over bed table. It was noted that Resident #98 had both feet pressed firmly against the foot board of the bed and legs bent at the knees and appeared to be uncomfortable in the bed in it's position. When asked about the observation, Resident #98 stated that the bed was not comfortable. Resident #98 stated, I am 6 foot 5 and I don't fit in this bed.</p> <p>During an interview, on 04/03/24 at 10:59 AM, with the Director of Environmental Services, the concern was brought to his attention. The Director of Environmental Services confirmed that the resident was on a standard air mattress and that he and his staff would provide a larger bed for the resident.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167</p> <p>Based on observation, interview and record review, the facility failed to follow the shower schedule for Resident #19 to ensure he received his 2 showers per week. And the facility failed to ensure a certified nursing assistant communicated Resident #92's desire for outside activities to the Activity Director.</p> <p>The findings included:</p> <p>1) Clinical record review revealed Resident #19 was admitted to the facility on [DATE] and 01/20/24, with diagnoses that included anxiety disorder, and depression. Review of the quarterly minimum data set (MDS) assessment, reference date 03/12/24, revealed a brief interview for mental (BIMS) status score of 15, which indicated Resident #19 was cognitively intact. This MDS recorded no mood or behavior issue. Further review of this MDS, under section GG for functional abilities and goals, it was documented Resident #19 had impairment on both lower extremities (related to double amputation of his lower extremities). This MDS also documented Resident #19 was dependent with activities of daily living (ADL) care included: toileting, hygiene, Shower/bath, lower body dressing, and chair/bed-to-chair transfer.</p> <p>Review of the comprehensive care plan completed 03/22/24 indicated Resident #19 had an ADL self-care deficit related to chronic medical condition of bilateral below the knee amputation (BKA). Intervention included: Encourage and assist with all ADL tasks as indicated, as tolerated by resident, including locomotion/ambulation, bathing, bed mobility, transfers, toileting tasks, meals, and personal/oral hygiene.</p> <p>Review of February, March and April 2024 progress notes lacked documented evidence of providing showers and/or refusal.</p> <p>On 04/01/24 at 11:17 AM Resident #19 was observed lying in bed, an interview was held with him, he stated that he doesn't get the care he requires, the staff doesn't get him out of bed. He doesn't receive shower as he should, he was supposed to receive shower twice a week, and it doesn't happen, certified nursing assistants said they don't have enough help.</p> <p>On 04/02/24 at approximately 9:00 AM Resident #19 was observed lying in bed.</p> <p>On 04/03/24 at 10:00 AM Resident #19 was noted lying in bed. At 10:28 AM an interview was held with Resident #19 an inquiry was made regarding whether he had a shower this week. He voiced that his scheduled showers are on Tuesdays and Fridays, he hadn't received his shower on Tuesday (4/2/24), the staff didn't get him up as they have lost his Hoyer lift pad. Resident #19 revealed he wanted to get up.</p> <p>On 04/04/24 at 08:52 AM Resident #19 was noted lying in bed. During that time an interview was conducted with the resident, an inquiry was made regarding whether staff got him up and out of bed this week. Resident #19 conveyed that he hasn't gotten up, because they had lost his Hoyer lift pad, they've just brought it back to him today.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/04/24 at 1:55 PM an interview was held with the director of nursing (DON), she revealed that the resident's shower schedule was on Tuesdays and Fridays on the 3-11 shift and as needed; he received showers on 03/08/24, 03/15/24, 03/18/24, and 03/29/24. When asked for additional documented evidence of the shower. The DON revealed she was going to obtain the bin that had the shower records. The DON carefully searched the bin and voiced that she didn't find any additional documented shower for March and April 2024 for Resident #19. The DON further revealed Resident #19 should have received a shower on 04/02/24, there was no documented evidence of shower. She added the last documented shower was on 03/29/24. During the interview process the DON was made aware of concern related to Resident #19 hasn't gotten up for 3 days during the survey process due to his Hoyer pad not being available, it was found in another resident room at the North unit. The DON advised that they'd found the Hoyer pad in another resident' room and they took it to the laundry.</p> <p>25404</p> <p>2) Review of the record revealed Resident #92 was admitted to the facility on [DATE]. Review of the current Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #92 had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of the Admission MDS dated [DATE] documented it was very important for the resident to go outside.</p> <p>During an interview on 04/01/24 at 12:48 PM, Resident #92 stated she would like to go outside. Resident #92 stated she had asked the Certified Nursing Assistants (CNAs) to go outside, and they told her there were not permitted to take her out. Resident #92 stated she has asked staff, but has to wait for her friend to come and take her outside. When asked if the activity staff or any other staff have offered to take her outside, the resident stated none have offered.</p> <p>During an interview on 04/04/24 at 12:20 PM, the Activity Director stated if the CNAs would have told her the resident wanted to go outside, she or her staff would have taken her out.</p> <p>During a supplemental interview on 04/04/24 at 12:44 PM, in the presence of the Activity Director, when asked again about going outside, Resident #92 stated the CNAs tell her they don't have time to take her outside as they are too busy.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>32078</p> <p>Based on record review and interview, the Facility failed to provide appropriate beneficiary notices for 3 of 3 sampled residents reviewed for Beneficiary Protection Notification (Residents #58, #110, and #89).</p> <p>The findings included:</p> <p>On 04/02/24 at 10:20 AM, the Administrator was provided a sample list of 3 residents who had been, or still were, residents in the facility and had been discharged from Medicare Part A services. A SNF Beneficiary Protection Notification (BPN) Review Worksheet (Form CMS-20052) was provided to be completed for each resident.</p> <p>On 04/02/24, the following documentation was provided by the Administrator:</p> <p>1) Resident #58's BPN Review worksheet showed Resident's last covered day of Part A Services was on 12/05/23. The facility had initiated the discharge from Part A Services when benefit days were not exhausted. Based on record review, this resident remained in the facility. The facility provided Resident #58 with a NOMNC (CMS Form 10123) on 12/05/23. Based on regulation, The NOMNC (Form CMS 10123), is given by the facility to all Medicare beneficiaries at least two (2) days before the end of a Medicare covered Part A stay. Resident #58 received his NOMNC on the day his Part A services were ending.</p> <p>Also, due to the fact that this resident chose to remain in the facility, he should have also been provided with a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN, CMS Form 10055), but he never received this notice. It is the facility's responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial responsibility for those services.</p> <p>2) Resident #110's BPN Review worksheet showed Resident's last covered day of Part A Services was on 02/19/24. The facility had initiated the discharge from Part A Services when benefit days were not exhausted. Based on record review, this resident remained in the facility. The facility provided Resident #110 with a NOMNC (CMS Form 10123) on 02/19/24. Resident #110 was not provided a copy of the NOMNC least two days before the end of a Medicare covered Part A stay. Resident #110 received his NOMNC on the day his Part A services were ending.</p> <p>Also, due to the fact that this resident chose to remain in the facility, he should have been provided with a SNF ABN (CMS Form 10055), which he did not receive.</p> <p>3) For Resident #89, no completed BPN worksheet or copy of the Resident's NOMNC was provided to this surveyor for review. However, documentation was provided showing that at the end of Resident #89's Part A services, the Resident's representative requested an expedited appeal of the decision to discharge the Medicare beneficiary.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Expedited Appeal Documentation Request was sent to the Facility's Social Services Director on 02/24/24 requesting specific documentation for the appeal (copy of the Notice of Medicare Non-Coverage, copy of the Detailed Explanation of Non-Coverage, and copy of specific items in the beneficiary's medical record from the last 7 days). The form stated, Failure to submit the information requested above could affect the decision of the Medicare QIO regarding the appeal of the termination of coverage notice.</p> <p>The Appeal was rejected on 03/08/24 due to the BFCC-QIO [Beneficiary and Family Centered Care Quality Improvement Organization] received insufficient medical records or other necessary documents within the required time frame.</p> <p>On 04/03/24 at 2:30 PM, the Administrator stated that a new Social Services Director was just recently hired and was not here at the time the notices for Residents #58, #110, and #89 were provided, so she would not have any further information to provide. The Administrator was unaware that a second beneficiary notice, SNF ABN (CMS Form 10055), was required when a resident was discharged from Part A services with benefit days remaining and chose to remain in the facility.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404</p> <p>Based on observation, interview, record review, and policy review, the facility failed to ensure timely Activities of Daily Living (ADL) care for 3 of 6 sampled residents, as evidenced by a lack of timely incontinence care for Residents #23 and #89, failure to trim a fingernail for Resident #23, and failure to ensure mouth care for Resident #1.</p> <p>The findings included:</p> <p>Review of the policy ADL Care and Services, revised 01/2024 documented, Procedure: . 4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, nail care, and oral care); . c. Elimination (toileting) .</p> <p>1) Review of the record revealed Resident #23 was admitted to the facility on [DATE], admitted to Hospice services on 03/04/22, and moved to her current room on 07/14/22. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #23 was severely cognitively impaired and dependent upon staff for all ADL care. This MDS also documented Resident #23 was always incontinent of bowel and bladder.</p> <p>Review of the current care plan initiated on 07/02/20 documented Resident #23 was at risk for further skin alteration related to limited mobility and a history of sacral pressure injuries and moisture associated dermatitis. Interventions included to provide incontinent care as needed. A care plan initiated on 07/23/20 documented the resident was incontinent of urine and dependent upon staff for care. This care plan also documented to provide incontinent care as needed.</p> <p>During a medication pass observation for Resident #23 on 04/03/24 at 4:54 PM, a urine odor was noted. Staff K, Registered Nurse (RN) administered medications through a PEG tube (a feeding tube surgically placed in the stomach). Upon start of the administration, a towel was noted around the end of the feeding tube. Upon completion of the medication administration the RN washed his hands and stated he was done. The RN was asked to observe if Resident #23 needed incontinence care. Upon further observation, the adult brief and draw pad was noted to be soiled. The RN stated he would ask a Certified Nursing Assistant (CNA) to clean her up.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the continued observation on 04/03/24, Staff G and Staff H, both CNAs, disrobed Resident #23, who was noted to be saturated with both tube feeding and urine around and on the adult brief, onto the draw sheet, a bath towel/blanket folded in four, and soaked through the draw sheet onto the fitted sheet. A very strong urine odor was noted upon disrobement. Two large, healed pressure injuries were noted to the buttock. When asked about change of shift process at 3 PM and their routine, Staff G, CNA, explained they do not do any walking rounds with the previous shift. The CNA stated they get their assignment and do a quick round, but don't pull down sheets or blankets, then they are expected to do vitals first, and then pass water, because hydration is a priority. The CNA stated they were unaware the resident needed to be changed. The CNAs needed to provide a full bed bath due to the incontinence. During the bath, the fingers of the resident's right hand were curled closed. Upon opening the resident's fingers, the third fingernail to the resident's left hand was noted to be extremely long and in need of trimming.</p> <p>During an observation on 04/04/24 at 8:56 AM, the Director of Nursing (DON), agreed with the excessively long fingernail that needed trimming. Resident #23 again had the fingers of her left hand curled up. A strong urine odor was again noted, and the DON agreed the resident needed incontinence care, noting urine on the draw pad.e for Residents #23 and #89, failure to trim a fingernail for Resident #23, and failure to ensure mouth care for Resident #1.</p> <p>2) Review of the record revealed Resident #89 was admitted to the facility on [DATE] and had resided on the 200 pod the entire time. Review of the Admission MDS assessment dated [DATE] documented the resident was totally dependent on staff for all ADL care, and the resident was frequently incontinent of both bowel and bladder. Review of the current care plan initiated on 01/02/24 documented Resident #89 had an ADL self-care deficit. A care plan initiated on 01/26/24 documented the resident was at risk for complications related to bowel and/or bladder incontinence, and staff were to provide incontinence care with each incontinence episode as tolerated.</p> <p>During an interview on 04/01/24 at 11:40 AM, the son of Resident #89 stated his mother was up in a wheelchair yesterday for first time in 21 days, but then had to beg to get her back into bed. The son explained staff got her up out of bed and into her wheelchair at about 2 PM, and did not get her back into bed until nearly 10 PM. The son explained that either he or his sister are with their mother 24 hours a day.</p> <p>During an interview on 04/01/24 at 4:38 PM, the daughter of Resident #89 stated, It's a fight with staff to get mom out of bed and fight to get back (into bed). The daughter explained the previous day her mom was up in the chair for 7 or 8 hours, and when staff put her back to bed, she was saturated. When asked if the urine went through to the mechanical lift sling, the daughter stated it did, and then motioned over the sling in a circular motion, showing a large area of where the sling was previously wet. The daughter explained staff do get her up for a shower twice weekly, but then put her back into bed as soon as the shower is done. The daughter explained that her mother gets antsy being in bed all of the time and will start to fidget.</p> <p>3) Review of the record revealed Resident #1 was admitted to the facility on [DATE], and moved to her current room on 03/28/24, after a short-term hospital stay. Review of the Quarterly MDS assessment dated [DATE] documented the resident was totally dependent upon staff for all ADL care.</p> <p>Review of current orders revealed Resident #1 received nutrition via a feeding tube and did not take in any oral food or fluids.</p> <p>(continued on next page)</p>		

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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	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 04/02/24 at 9:04 AM revealed Resident #1 was in need of mouth care, with a white coating noted over her teeth.</p> <p>During an observation on 04/02/24 at 2:05 PM, Staff P, CNA, was just finishing up with personal care, and Staff I, Registered Nurse (RN) was providing a breathing treatment. Observation after the breathing treatment revealed the resident's mouth needed to be cared for, as the white coating was still noted over her teeth.</p> <p>On 04/03/24 at 10:58 AM, a white accumulation of secretions was observed on the bottom lip of Resident #1. The resident's teeth appeared the same as the previous day. After a wound care observation with Staff I, RN and the Wound Care Nurse, the buildup of white accumulated secretions was noted covering half of the resident's bottom lip. When asked about mouth care and the observed white accumulation on the resident's bottom lip, the Wound Care Nurse was able to remove the accumulated secretions with a gloved hand, and stated she would provide additional mouth care.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404</p> <p>Based on observation, interview, and record review, the facility failed to ensure a specialty air mattress and protective boots were provided for 1 of 2 sampled residents. Resident #1 was identified as having a facility acquired pressure injury.</p> <p>The findings included:</p> <p>Review of the record revealed Resident #1 was admitted to the facility on [DATE] and was moved to her current room after a short hospitalization stay on 03/28/24. Review of the current Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident was totally dependent upon staff for all Activities of Daily Living and had three current pressure injuries. A care plan initiated on 01/11/24 documented Resident #1 had a pressure injury to her sacrum and an intervention included the use of a pressure relieving/reducing mattress as ordered or indicated. A care plan initiated on 03/21/24 documented the resident had a stage 2 pressure injury to her left heel. This care plan lacked the intervention of offloading the resident's heels or the use of protective boots.</p> <p>Review of the physician wound care progress notes dated 03/26/24 and 04/02/24 both documented the use of a low air loss mattress and offloading heel protective boots. Review of the current orders lack these interventions.</p> <p>An observation on 04/01/24 at 4:23 PM revealed Resident #1 in bed, lying on her back on a regular mattress. The resident did not have on any protective boots.</p> <p>An observation on 04/02/24 at 2:05 PM revealed Resident #1 lying on her back, slightly leaning to her right side on the regular mattress. Bilateral boots were not noted.</p> <p>On 04/03/24 at 10:58 AM, Resident #1 was observed lying on her back, slightly leaning to her right side, on the regular mattress.</p> <p>A wound care observation was made on 04/03/24 at 2:39 PM with Staff I, Registered Nurse (RN) and the wound care nurse. When asked about a specialty air mattress, the wound care nurse confirmed Resident #1 did have one while residing in her room on the other unit, prior to her hospitalization . The wound care nurse confirmed she had not noticed the lack of the specialty air mattress since her return to the facility on [DATE], six days earlier.</p> <p>During an observation on 04/03/24 at 3:40 PM with the Unit Manager, a specialty air mattress was noted on the bed in the room occupied by Resident #1 prior to hospitalization . When asked why the air mattress was not being currently used by Resident #1, the Unit Manager stated the wound care nurse usually catches these things.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893</p> <p>Based on observations, interviews and record reviews, the facility failed to provide nutrition via enteral tube feeding as ordered for 4 of 4 residents reviewed for tube feeding (Residents #100, 29, 67, 1).</p> <p>The findings included:</p> <p>1) Resident #100 was admitted to the facility on [DATE] to 02/12/24 and most recently readmitted to the facility on [DATE] after being sent out to the hospital for pulling out her Peg tube. According to the resident's most recent full assessment, a 5-day Minimum Data Set (MDS), dated [DATE], Resident #100 had a Brief Interview for Mental Status (BIMS) score of 06, indicating severe cognitive impairment. Resident #100's diagnoses at the time of the MDS included: Hemiplegia following CVA affecting left non-dominant side, renal insufficiency, Diabetes, CVA, Malnutrition, Gastrostomy status, Dysphagia following cerebral infarction, Dysphagia.</p> <p>Resident #100's diet orders included:</p> <p>NPO (nothing by mouth) diet, 01/29/24.</p> <p>Enteral Feed - Resident on enteral feeding of Glucerna 1.5 via pump at the rate of 50ml/hr to start at 1400 until completion of 1000ml. Autoflush with H2O at 50ml/hr x 20 hours. - 01/29/24.</p> <p>Resident #100's Care plan for Tube feeding, dated 02/06/24, documented, Resident requires tube feeding related to Dysphagia</p> <p>The goals of the care plan included:</p> <ul style="list-style-type: none"> o Resident will remain free of side effects or complications related to tube feeding through review date. Target date 05/30/24. o Resident will maintain adequate nutritional and hydration status through review date. Target Date: 05/30/2024. <p>Interventions to the care plan included:</p> <ul style="list-style-type: none"> o Follow physician orders regarding nutrition order and flushes. o NPO o RD to monitor/evaluate quarterly and PRN. o TURN OFF feeding during care when head of bed (HOB) is down <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/01/24 at 9:49 AM Resident #100 was observed in bed with tube feeding (TF) initiated at 50 milliliters per hour (ml/hr). The date mark on the container documented that it was initiated on 04/01/24 at 00:05. At the time of the observation, there was approximately 950 ml remaining in the 1000 ml container of supplement. At a rate of 50 ml/hr, Resident #100 should have received 450 ml of the supplement in the 9 hours that the pump had been initiated.</p> <p>On 04/03/24 at 8:38 AM, Resident #100 was observed in bed with tube feeding initiated at 50 ml/hr. The date mark on the container of supplement documented that it was initiated on 04/02/24 at 6:30 PM. At the time of the observation, there was approximately 450 ml remaining in the 1000 ml container of the supplement. At a rate of 50 ml/hr, Resident #100 should have received 700 ml of the supplement in the 14 hours that the pump had been initiated.</p> <p>During an interview, on 04/04/24 at 7:23 AM, with Staff B, LPN and Staff C, RN, when asked about the feeding being stopped at any time during her shift, Staff B replied, not at all. I stopped it at around 2 AM and gave her medication and started it again and at 5. I stopped for medication and started again. Normally if it stops there is an alarm. I stopped for 10-15 minutes twice on my shift for her to be changed.</p> <p>Staff C stated that she did not stop the feeding during her shift (3-11). Staff C stated, the time on the bottle (date mark) is not right. When I started my shift there was one warning. It was a warning from the first shift, and I stopped it at around 2 PM for bowling. When she came back, I resumed the one that she had. On the second shift, I hung the other one at around 19:00 (7:00 PM). Sometimes when the CNA change her, they stop it. I did not stop it during my second shift, I did not stop the feeding for any reason. I have to stop her for medications for 10-15 minutes depending on how her pain is.</p> <p>Review of Resident #100's electronic health records revealed no documentation to justify not having met the order for tube feeding.</p> <p>2). Resident #29 was admitted to the facility on [DATE]. According to the resident's most recent full assessment, a Quarterly MDS, dated [DATE], Resident #29 had a BIMS score of 10, indicating moderate cognitive impairment. Resident #29's diagnoses at the time of the MDS included: Anemia, Hyponatremia, Anxiety disorder, Depression, Dysphagia.</p> <p>Resident #29's care plan for nutrition, initiated on 07/20/23 with a revision date of 08/28/23, documented, Resident is at risk for alteration in nutrition/hydration related to mechanically altered diet, PEG feeding, poor p.o. intake, depression, anxiety.</p> <p>The goal of the care plan was documented as, The resident will tolerate current diet and tube feeding & flushes order through next review. Initated 07/20/23 with a revision date of 03/27/24 and a target date of 06/18/24.</p> <p>Interventions to the care plan included:</p> <p>Honor preferences.</p> <p>Monitor tolerance to tube feeding.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide tube feeding & flushes per MD order.</p> <p>RD to evaluate and make diet change recommendations PRN (as needed).</p> <p>Resident 29's diet orders included:</p> <p>Diet orders included:</p> <p>Regular diet, Pureed texture, Thin consistency - 07/20/23.</p> <p>Enteral feed - Resident on enteral feeding of Jevity 1.5 via pump at the rate of 50ml/hr to start at 2230 and stop at 0830 (500ml) Autoflush with H2O at 60ml/hr.</p> <p>On 04/02/24 8:36 AM resident noted not to be in her room with the tube feeding at the resident's bedside. The date mark on 1000 ml container of Jevity 1.5 documented initiated on 04/01/24 at 10:30 PM with approximately 650 ml remaining. At a rate of 50 ml/hr, resident should have received 500 ml of the supplement in the 10 hours since being initiated.</p> <p>On 04/03/24 at 8:52 AM, Resident #29 was observed in the common area of the pod eating breakfast independently with TF still attached and initiated at 50 ml/hr. At the time of the observation, there was approximately 600 ml remaining of the 1000 ml container. The date mark on container documented initiated on 04/02/24 at 21:00 (9:00 PM - an hour and a half earlier than the order dictated). At a rate of 50 ml/hr, Resident #29 should have received 650 ml of the supplement.</p> <p>During an interview, on 04/04/24 at 7:17 AM, with Staff D, LPN, when asked about the tube feeding order for Resident #29, Staff D replied, the previous shift started at 10:30 PM and she goes until 8:30 AM. Staff D confirmed observation of 1000 ml container, and stated, when they clean her, they stop and start again. It takes 10-15 to clean and change her every 2 hours.</p> <p>Review of the resident's records revealed no documentation to justify not providing tube feeding as ordered.</p> <p>On 04/04/24 at 8:32 AM, with the Registered Dietitian (RD), the Administrator and the Director of Nursing (DON), when asked about the order for Resident #29, the RD stated that the tube feeding should be from 10:30 PM to 8:30 AM until 500 ml of the supplement has been infused.</p> <p>39167</p> <p>3) Record review revealed Resident #67 was admitted to the facility on [DATE] and 02/28/24 with diagnoses including: Cerebral vascular accident, hemiparesis (one side weakness), and Malnutrition. Review of the admission minimum data set (MDS) assessment, reference date 03/03/24, recorded a brief interview for mental status score of 06, which indicated Resident #67 was moderately cognitively impaired. This MDS recorded no mood and behavior issue. Review of physician order dated 03/04/24 for enteral feeding of Osmolite 1.5 at 70ml/hr x 20 hours or until 1400ml has infused. Diet order as of 02/29/24 was nothing by mouth (NPO). Review of nutrition assessment dated [DATE] recorded Resident #67 was at risk for malnutrition, her diet was NPO, enteral feeding was the sole source of nutrition at this time.</p> <p>(continued on next page)</p>		

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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	
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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of care plan completed 03/27/24 indicated Resident #67 required tube feeding for nutritional needs. She was at risk for alteration nutrition/hydration related to increased nutrient needs. Interventions included: Explain and reinforce to the resident the importance of maintaining the diet ordered. Provide, and serve diet as ordered.</p> <p>On 04/01/24 at 11:05 AM Resident #67 was noted lying in bed sleeping, the tube feeding was off, there was a bottle of osmolite formula hanging on the feeding pole, the bottle had 200 ml remaining. There was a basin on the bedside table, there were wet napkins inside the basin.</p> <p>On 04/02/24 at 8:45 AM Resident #67 was noted lying in bed, she was connected to the feeding tube, she was receiving feeding formula of Jevity 1.5 cal at 70 ml/hr. There was a basin on the bedside table, there were wet napkins inside the basin. An interview process was started with Resident #67, she conveyed she has been spitting up and she doesn't know what the cause may be.</p> <p>On 04/03/24 at 10:22 AM Resident #67 was noted lying in bed, she was receiving tube feeding of Osmolite 1.5 cal at 70ML/hr. There was a basin on the table, and wet napkins inside the basin. Resident #66 revealed she has been spitting up and her mouth tasted bitter, she reported to the nurse who said it may be due to the medications she's taking.</p> <p>On 04/04/24 at 10:04 AM an interview was held with the registered dietitian (RD), she voiced Resident #67's diet was Osmolite formula, to be on at 2 PM and off at 10 AM. The RD revealed Osmolite and Jevity are similar, but Osmolite is gentler in the stomach, as far as calorie wise and protein wise, they're pretty much the same. When asked, would she expect the nurses to use the formulars interchangeably, would nurses provide Osmolite one day and Jevity the next day, the RD stated the order says Osmolite. They must follow the order. The RD was asked if she was aware that the resident has been spitting up and she reported her mouth tasted bitter. The RD revealed that she was not aware.</p> <p>On 04/04/24 at 11:13 AM an interview was held with Staff Q, a license practical nurse (LPN). An inquiry was made regarding which feeding formula Resident #67 received on 04/02/24. Staff Q revealed, around 11:00 AM when she checked Resident #67, she realized that the resident was receiving the wrong feeding formula (Jevity 1.5 cal instead of Osmolite 1.5 cal). She took it down, and hanged Osmolite but the feeding wasn't going to start until 2 PM. She voiced she usually checks the resident early in the morning when she comes in, but that day she didn't get a chance to check her until later. When inquired regarding Resident #67's had been spitting up. Staff Q divulged a certified nursing assistant had informed her the resident was spitting up, but she doesn't know why she was spitting up.</p> <p>On 04/04/24 at 11:24 AM an interview was held with Staff R, a certified nursing assistant (CNA), she voiced that she had informed the attending nurse (Staff Q) regarding Resident #67 had been spitting up. Staff R stated, it is like every minute her mouth is filled up.</p> <p>On 04/04/24 at 1:19 PM an additional interview was held with Staff Q; an inquiry was made whether she notified the registered dietitian or the speech therapist that the resident was spitting up. She stated no.</p> <p>25404</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4) Review of the record revealed Resident #1 was admitted to the facility on [DATE] and moved to her current room on 03/28/24 after a short hospitalization . Review of the current Quarterly MDS assessment dated [DATE] documented the resident was fed entirely via a tube.</p> <p>Review of the current order dated 03/20/24 documented Resident #1 was to receive Jevity 1.5 calorie at 50 milliliters (ml) per hour, continuously for 20 hours. This order also documented an auto water flush of 35 ml per hour for 20 hours was to be administered. The order was updated on 04/04/24, after surveyor intervention, to read the Jevity was to run until 1000 ml (a full container) was infused.</p> <p>On 04/01/24 at 4:03 PM, the tube feeding pump did not appear to be running. Staff I, Registered Nurse (RN), entered the room. When asked if the tube feeding was running, the nurse went to the pump, appeared to have difficulty, and stated she was going to get help. The RN returned, stated it had been running earlier, but it had suddenly stopped. (Photographic Evidence Obtained). Staff V, RN, came into the room and set the feeding pump. When asked the rates of administration for the feeding and water flush, both RNs stated they were the same at 50 ml per hour. This was observed by the surveyor.</p> <p>During an observation on 04/02/24 at 9:04 AM, the water flush remained at 50 ml per hour, instead of the ordered 35 ml per hour (Photographic Evidence Obtained).</p> <p>On 04/03/24 at 2:39 PM, Staff I, RN, changed the tube feeding canister and tubing setup, and started the feeding pump. When she was finished, Staff I was asked to show the surveyor the settings for both the feeding and the water flush, and they were both noted to be running at 50 ml per hour. Observation of the water flush bag revealed a label that documented the water flush was to run at 35 ml per hour. Both Staff I, RN, and the wound care nurse agreed, and the rate for the water flush was changed to 35 ml per hour.</p> <p>An observation on 04/04/24 at 11:28 AM revealed the tube feeding pump was off, the tube feeding tube was still hooked to Resident #1, and there was 300 ml of formula left in the container. The current orders were reviewed and documented the tube feeding was to continue until all 1000 ml were administered.</p> <p>During an interview on 04/04/24 at 11:40 AM, when asked the status of the tube feeding, Staff J, Licensed Practical Nurse (LPN), stated she had turned it off at 10 AM, because, that is what the orders says. The LPN stated, but I saw the order to administer the 1000 ml and wasn't sure what to do. The LPN agreed the full 1000 ml container was not provided to Resident #1.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404</p> <p>Based on record review and interview, the facility failed to ensure documented provision of dialysis and ongoing communication with the dialysis facility for 1 of 1 sampled resident (Resident #55).</p> <p>The findings included:</p> <p>Review of the policy, Dialysis Care revised 08/2023 documented, Standard: To encourage residents' compliance with dialysis schedule/appointment, . Procedure: 2. Facility personnel will provide information that is useful or necessary for the care of the resident to the dialysis center as needed. 4. Correspondence from the dialysis center will be addressed by facility staff and will be recorded in the plan of care as indicated.</p> <p>Review of the record revealed Resident #55 was admitted to the facility on [DATE]. Review of the orders revealed Resident #55 was scheduled for dialysis services at a dialysis center on Monday, Wednesdays, and Fridays.</p> <p>On 04/04/24 in the afternoon, staff at the North nurses' station were asked how the facility ensures ongoing communication with the dialysis centers. Nursing staff sitting in the area handed the surveyor a binder labeled Dialysis.</p> <p>During a side-by-side review of the record and the dialysis binder with the Director of Nursing (DON) on 04/04/24 at 4:14 PM, to review the provision of dialysis and communication for the month of March 2024, the following was noted:</p> <p>The Dialysis Communication Forms for Resident #55 were not found for 03/01/24, 03/06/24, 03/08/24, 03/11/24, 03/13/24, 03/15/24, 03/25/24, and 03/29/24.</p> <p>Progress notes lacked evidence Resident #55 went to the dialysis center, or the refusal of services, on 03/08/24.</p> <p>Progress notes lacked any documentation related to dialysis on Friday 03/22/24, but did note the resident went to the dialysis center on Saturday 03/23/24.</p> <p>Progress notes lacked any information related to the resident's return from dialysis on 03/29/24.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**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 competent nursing staff during care for 2 of 8 sampled residents observed. Staff failed to ensure an order for the use of oxygen and failed to replace an empty water bottle for the oxygen of Resident #1; failed to ensure proper order of care for the wound and tube feeding for Resident #1, failed to ensure competency for setting the tube feeding pump for Resident #1, and failed to properly administer medications through the PEG tube (feeding tube surgically placed in the stomach) for Resident #23.</p> <p>The findings included:</p> <p>1) Review of the policy Oxygen Administration revised 12/2023 documented, General Guidelines: 1. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or other device per physicians' orders and/or facility protocol.</p> <p>Observations on 04/01/24 at 4:03 PM, on 04/02/24 at 9:04 AM and 2:05 PM, and on 04/03/24 at 10:58 AM, all revealed Resident #1 wearing humidified oxygen via nasal cannula.</p> <p>Review of the record revealed Resident #1 was admitted to the facility on [DATE], and moved to her current room on 03/28/24, after a short hospital stay. Review of the current orders lacked any oxygen administration order.</p> <p>An observation on 04/03/24 at 2:39 PM revealed the continued oxygen administration, but the water container that provided the humidified oxygen was empty. On 04/04/24 at 11:28 AM, the water bottle for the humidified oxygen was empty. A current care plan initiated on 04/10/23 documented Resident #1 required oxygen therapy related to ineffective gas exchange.</p> <p>During an interview on 04/04/24 at 11:40 AM, when asked what she looks for when a resident is on oxygen, Staff J, Licensed Practical Nurse (LPN), explained she monitors lung sounds and oxygen levels, ensures the tubing is changed, and looks at the water bottle when humidified oxygen is used. Staff J volunteered she noticed during her 7 AM rounds this morning, that two of her residents needed new water bottles for their oxygen, as they were both empty. When asked which residents, Staff J named Resident #1, and further stated she hadn't had a chance to get them yet.</p> <p>During a side-by-side review of the record, Staff J was unable to locate a current order for the resident's oxygen use, and stated the resident needs the oxygen as her oxygen saturation was 94% this morning on 3 liters of oxygen.</p> <p>2) A request was made on 04/03/24 in the morning to observe wound care. Staff I, Registered Nurse (RN) stated she would be doing wound care and changing the tube feeding set about 2:15 PM. The surveyor requested to observe both procedures.</p> <p>(continued on next page)</p>		

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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	
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/03/24 at 2:39 PM, wound care was provided by Staff I, RN, accompanied by the wound care nurse. When asked who usually provided the wound care, the wound care nurse explained she does the weekly rounds with the wound care physician and does care for the surgical wounds, but the direct care nurses complete the care for the long term residents and other wounds that are not surgical. The wound care nurse was asked to allow Staff I, RN, to complete the care without cueing, unless she felt it necessary, as the wound care nurse normally is not with the direct care nurses during wound care.</p> <p>Staff I, RN set up supplies to change the tube feeding set and to provide wound care. Both nurses donned gloves and gowns upon entering the room. Staff I, RN, opted to start with the wound care to the resident's sacral wound. The wound care nurse needed to cue Staff I during the cleaning of the wound, cued her to change gloves after cleaning the wound, and cued her during the process of applying the gentamicin ointment.</p> <p>Staff I then removed her gloves, washed her hands, and applied new gloves, but did not change her gown. Staff I primed the tubing for the feeding, and hooked it up to the resident's PEG tube, her contaminated gown touching the bed and tube feeding equipment. The wound care nurse also cued Staff I to flush the feeding tube.</p> <p>Upon completion, when an incorrect water flush rate was identified by the surveyor, Staff I, was unable to reprogram the pump and needed the wound care nurse to complete the change. Staff I had been observed on 04/01/24 at 4:03 PM having difficulty with the feeding tube machine and needed to ask another nurse to set up the pump to administer the feeding and water flush.</p> <p>When asked the order in which procedures are to be done for residents, specifically clean and dirty procedures, the wound care nurse stated the clean procedure should be completed first, followed by the dirty procedure. The wound care nurse agreed Staff I should have changed the tube feeding set prior to doing the wound care, or change her gown as needed between procedures if done out of appropriate order.</p> <p>3) Review of the policy Administering Medications through an Enteral Tube revised November 2018 documented, 12. Administer medication by gravity flow. a. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion. b. Open the clamp and deliver medication slowly. c. Begin flush before the tubing drains completely. 14. When the last of the medication begins to drain from the tubing, flush with 15 ml (milliliters) warm purified water (or prescribed amount). 15. Quickly clamp the tubing when the flush is complete. Remove syringe.</p> <p>A medication pass observation for Resident #23 was made on 04/03/24 beginning at 4:54 PM, with Staff K, Registered Nurse (RN). The RN prepared 10 ml of liquid colace, along with two 10 ml water flushes for before and after administration. The amount was verified by the RN.</p> <p>Upon entering the room, Staff K checked for residual by pulling back on the syringe that he attached to the PEG. There was none. The RN removed the plunger of the syringe, attached the syringe back onto the PEG and poured 10 ml of water into the tube followed by pushing 30 ml of air through the tube. The RN then removed the syringe, took out the plunger, reattached the syringe and administered the medication. The RN then pushed 30 to 60 ml of air through the tube. The RN followed the same procedure for the last 10 ml water flush. During the administration of the water and the medication, the fluid were observed running out the opened side port of the PEG tube. A pink stain, the color of the medication, was noted on the towel below the PEG.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The RN did not notice the water and medication coming out of the PEG tube or the pink stain on the towel. When brought to his attention, the RN stated he would do it again. Staff K obtained another dose of the colace along with two 10 ml water flushes, and administered the water and medication in the same manner, providing 30 to 60 ml of air between each step. When asked why he was pushing air into the resident's tube, Staff K stated, Because you are here. I saw it go down.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32078</p> <p>Based on observation, interview and record review, the facility failed to ensure complete and accurate medical records for 4 of (Residents #20, #5, #98, #53, and #55).</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1) Resident #20 had the following current orders documented on her March 2024 electronic medication and treatment administration record (eMAR/eTAR): <ol style="list-style-type: none"> a) Treatment for Bilateral Buttocks: Cleanse with soap and water, pat dry, and apply Zinc Oxide every shift for prevention. b) Mupirocin External Ointment 2 % Apply to Mid back topically every day shift for wound care; Cleanse wound to mid back with Dakin's, pat dry, apply skin prep to peri wound, lightly fill wound with plain packing strip moistened with mupirocin, change daily and PRN (as needed). c) Nystop External Powder 100000 unit/gm apply to sacrum topically twice daily for rash d) Body audit daily every day shift for Skin observation e) Behavior monitoring every shift. <p>A review of the March 2024 eMAR and eTAR showed no staff initials signifying completion of the above tasks for day shift on 03/29/24, nor was there any documentation stating why tasks were not completed.</p> <p>On 04/04/24 at 6:15 PM, the Director of Nursing and Administrator were informed of missing initials/documentation in the medication and treatment records.</p> <p>38893</p> <ol style="list-style-type: none"> 2). Resident #5 was initially admitted to the facility on [DATE]. An Admission MDS, date 09/15/23 documented that the resident's diagnoses on admission included Dementia and Depression. <p>Review of Resident #5's electronic health record revealed that the resident did not had a Pre-Admission Screen and Resident Review (PASARR).</p> <p>On 04/02/24 at 10:48 AM, the Medical Records Clerk was unable to locate the documentation in Resident #5's paper-based charts.</p> <p>On 04/02/24 11:17 AM, the DON and Administrator were unable to locate the documentation in the resident's electronic and paper-based health records.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/02/24 12:19 PM, the Administrator stated that the resident came from another facility and has reached out to them for PASARR documentation.</p> <p>On 04/02/24 at 12:48 PM, the Administrator provided a copy of the resident's Level I PASRR dated 09/07/23 - Level II not required.</p> <p>3). Resident #98 was admitted to the facility on [DATE]. According to the resident's most recent full assessment, an Admission MDS, dated [DATE], Resident #98 had a BIMS score of 08. The MDS documented that Resident #98's height was 68 inches (5 feet 8 inches tall).</p> <p>A Patient Transfer form from the Hospital, dated 01/11/24, documented that Resident #98 was 6 feet 5 inches tall (77 inches).</p> <p>An Admission Nursing Evaluation dated 01/11/24 (upon admission to the facility) documented that the resident was 68 inches tall.</p> <p>A Nutrition Evaluation dated 01/18/24 documented that Resident #98 was 68 inches tall.</p> <p>During an interview with Resident #98, on 04/03/24 at 9:07 AM, Resident #98 was in bed with the head of his bed raised and breakfast on the resident's over bed table. During an interview with Resident #98, he stated, I am 6 foot 5 and I don't fit in this bed.</p> <p>During an interview , on 04/03/24 at approximately 9:30 AM, with the Director of Rehabilitation, the Director of Rehabilitation agreed that the resident was significantly more that 68 inches based on being taller than he was at over 6 feet tall.</p> <p>During an interview, on 04/04/24 at approximately 12:30 PM, with the Registered Dietitian (RD), the RD was made aware of the Nutrition Assessment documenting the incorrect measurement of Resident #98 being 68 inches. The RD agreed that the resident was not 68 inches and stated that she would reassess the resident for nutritional needs based on the resident being 6 foot 5 inches tall (77 inches).</p> <p>39167</p> <p>4) Record review revealed Resident #53 was admitted to the facility on [DATE] with diagnoses included: macular degeneration (loss in the center of the field of vision). The annual minimum data set (MDS) assessment, reference date 02/29/24, recorded a brief interview for mental status score of 13, which indicated Resident #53 was cognitively intact. This MDS recorded Resident #53 exhibited moods related to little interest or pleasure in doing things. No behavior exhibited. Under section GG for functional abilities and goals, it indicated Resident #53 required set up or clean-up assistance with eating.</p> <p>On 04/01/24 at 9:24 AM Resident #53 was observed lying in bed covered up, his breakfast tray was on the table, untouched. He did not try to eat his food. At 9:42 AM Resident #53 did not eat anything, at 9:43 AM Staff S, a certified nursing assistant removed the tray from his possession. During that time an interview was held with Staff S, she voiced that Resident #53 doesn't like to eat, he only drinks his juice. Staff S added he would look at the tray and send it back. She encouraged him to eat by trying to feed him and he refused.</p> <p>(continued on next page)</p>		

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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	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/02/24 at 9:18 AM Resident #53 was noted lying in bed, his breakfast tray was on the table untouched, the tray included: fried egg, waffle, oatmeal, low fat milk 1%, mighty chocolate shake, and orange juice. This surveyor informed the resident that his tray was on the table, the surveyor asked him if he was going to eat. He voiced I don't want to eat. The surveyor then encouraged him to eat. He sat up, drank the milk and the nutritional shake, then laid back down. The surveyor encouraged him to drink the juice, he said he will drink it when he is ready. He continued to lay down. When inquired if he would like to have assistance with feeding, the surveyor would get staff to assist him, he vehemently said no I can feed myself. At 9:23 AM he sat up and continued to drink the milk, then he drank the orange juice.</p> <p>On 04/03/24 at 9:53 AM an observation was conducted on Resident #53 he was noted lying in bed, covered up. His tray was not on the table. The tray was found in the food cart, the food and drinks were untouched, he did not eat.</p> <p>On 04/03/24 at 1:05 PM an observation was made on Resident #53, he was noted lying in bed, the lunch tray was on the table. He drank his juice but did not eat the food. The surveyor encouraged him to eat but he refused. He sat up on the bed, but he did not attempt to eat the food.</p> <p>On 04/04/24 at 9:17 AM an observation was conducted in the resident's room, he was noted lying in bed, covered up. The tray was not on the table. During that time Staff T, a CNA came into the room. Staff T revealed that she was assigned to Resident #53. When asked did Resident #53 eat? She pleasantly said, oh yes, he ate 75%, when asked to see the tray, she removed the tray from the food cart, all the food was on the plate, he did not eat. The food in the tray included: fried eggs, toast with butter spread on it, a cup with some brown sugar, orange juice and a vanilla nutritional drink. He had a bowl of cold cereal (frosted flakes) on the table which was not open. The attending nurse (Staff U) was present at the 500 pod during that time. When asked Staff U did Resident #53 consumed 75% of the breakfast, Staff U looked at the tray, Staff U said no, that's not 75%, that's not even 25%. Staff U then divulged that the resident would drink his juice and nutritional drink, Staff U removed the drinks from the tray and brought it back to the resident. When asked Staff T what percentage or amount she was going to document for the meal consumption, she voiced she was going to document 75%.</p> <p>On 04/04/24 at 9:49 AM an interview was held with the registered/license dietitian (RD, LDN) regarding Resident #53, and a side-by-side review of the resident's record was conducted with the RD, a review of the ADL task for the amount/percentage of meal consumption was conducted. The RD was made aware of all the meal observations which were conducted during the survey process from (04/01 to 04/04/24). During the review, it was revealed there was lack of documentation and inconsistent documentation of the meal's consumption. It was revealed that on 3/26, and 3/27 there was no documentation for breakfast and lunch. On 3/28 no documentation for breakfast. 3/29 no documentation for dinner. 4/1, 4/2, and 4/3 no documentation for breakfast consumption. The RD acknowledged the findings. The RD was also made aware of the concern related to the incorrect amount of meal consumption Staff T said the Resident had consumed this morning. The RD was shown a picture of the tray, she was made aware that Staff T revealed the Resident consumed 75% of the breakfast. The RD agreed that it wasn't 75% consumption. The RD voiced that she relied on documentation of meals consumptions to make changes for the resident. The RD stated that accurate documentation would give insight on how much food the resident is being ingested to let her know if she needed to add additional interventions, adding supplements and update food preferences. She acknowledged the lack of documentation and inconsistent documentation of meal consumption.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>25404</p> <p>5) Review of the record revealed Resident #55 was admitted to the facility on [DATE]. Review of the current Admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, on a 0 to 15 scale, indicating the resident was cognitively intact.</p> <p>During an interview on 04/01/24 at 2:24 PM and again on 0402/24 at 1:14 PM, Resident #55 confirmed she was scheduled for outpatient dialysis services on Mondays, Wednesday, and Fridays, but there had been confusion about the transportation time. Resident #55 stated she received her treatments through a port in her right chest wall with two lines and had never had a fistula. Resident #55 stated she had an indwelling urinary catheter previously, but it had been removed.</p> <p>Further review of the record revealed the following duplications or inappropriate orders and incorrect documentation in the progress notes for Resident #55:</p> <p>a) There were three contradictory active orders related to the transportation service, dialysis center, pickup time, and dialysis chair time (time the treatment was to start).</p> <p>An order dated 02/13/24 documented the dialysis center as North Palm Beach dialysis center, with a pick up time of 7:30 AM by Modiv transportation, and a chair time of 8:30 AM.</p> <p>An order dated 02/27/24 documented the dialysis center as Davita, lacked a pickup time but had transportation with MK Unlimited, and a chair time of 9:30 AM.</p> <p>An order dated 03/22/24 lacked the dialysis center, lacked the name of the transportation service, but documented a pickup time of 8:45 AM, and lacked a chair time.</p> <p>b) There were four orders related to the resident's fistula, that the resident never had.</p> <p>An order dated 02/13/24 documented no blood pressure in the right arm. This order would be relevant if the resident had a fistula in that arm.</p> <p>An order dated 02/14/24 documented to gently palpate/auscultate bruit/thrill to right arm shunt/fistula every shift. If unable to obtain, notify the physician.</p> <p>An order dated 02/14/24 documented to monitor the right arm shunt/fistula for signs and symptoms of infection, temperature changes, swelling, pain, bleeding or other discharge, and any other abnormal findings. Document every shift and notify physician of abnormal findings.</p> <p>An order dated 02/14/24 documented to monitor the presence of a thrill and bruit to the right arm.</p> <p>c) There were two orders related to an indwelling urinary catheter.</p> <p>An order dated 03/13/24 documented to irrigate the urinary catheter for blockage, leakage, increased sediment, or decreased output.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An order dated 03/31/24 documented to maintain the indwelling urinary catheter. On or about 03/30/24 the progress notes stopped documenting about the urinary catheter, but lacked how, why, or when the urinary catheter was discontinued.</p> <p>d) Progress notes dated 03/27/24 documented Resident #55 was sent to the hospital and returned from the hospital related to fistula malfunctioning.</p> <p>e) There were two active orders related to obtaining blood sugar levels and when to notify the physician.</p> <p>An order dated 02/13/24 documented to obtain the blood sugar levels twice daily and to call the physician if the result was more than 200.</p> <p>An order dated 03/24/24 documented a sliding scale insulin regimen and to call the physician if the blood sugar was greater than 351.</p> <p>During an interview and side-by-side review of the record on 04/04/24 at 4:14 PM, the Director of Nursing (DON) explained the nurses were not discontinuing the previous orders upon receipt of new orders. The DON agreed that all the orders were showing on the electronic Medication Administration Record (MAR), which could be confusing. The staff also documented they were following all of the above contradictory or inappropriate orders.</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404</p> <p>Based on record review and interview, the facility failed to ensure timely provision of physician ordered antibiotics for 1 of 1 sampled resident (Resident #78).</p> <p>The findings included:</p> <p>Review of the record revealed Resident #78 was admitted to the facility on [DATE]. Review of the current Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating she was cognitively intact.</p> <p>A progress note dated 03/31/24 at 12:06 PM, by Staff N, the physician, revealed Resident #78 complained of a cough. The physician's plan included the initiation of the IV (intravenous) antibiotic Zosyn, to be given every 6 hours for seven days.</p> <p>Further review of the record revealed an order dated 03/31/24 at 12:41 for the placement of a midline (intravenous access). The order for the Zosyn was entered into the electronic medical record on 03/31/24 at 12:51 by Staff M, Registered Nurse (RN).</p> <p>A progress note written by Staff M, RN, on 03/31/24 at 2:44 PM revealed the IV access nurse was in the facility to insert the midline. Review of the March 2024 Medication Administration Record (MAR) revealed the Zosyn was not administered on 03/31/24 at 6:00 PM or on 04/01/24 at 12:00 AM. The Zosyn was started on 04/01/24 at 6:00 AM.</p> <p>During an observation and interview on 04/01/24 at 3:12 PM, Resident #78 was in bed and stated she had been in bed all day. The resident appeared ill and confirmed she had been diagnosed with pneumonia over the weekend. When asked about the IV antibiotics observed in the room, Resident #78 stated they had started that morning. An observation and interview on 04/02/24 at 1:30 PM revealed Resident #78 remained in bed, was feeling a little better, but stated she was still ill.</p> <p>During an interview on 04/04/24 at 10:17 AM, when asked about the process to initiate an ordered IV antibiotic for a current resident at the facility, Staff W, Licensed Practical Nurse (LPN) explained she would call to have the IV access staff to come to insert a midline and they would usually come within an hour or two. The LPN stated, Then we can start the IV (antibiotic) right away. The LPN explained they have many IV antibiotics in their in-house stock. When asked about Zosyn, the LPN thought they had it in stock, but was not sure. An observation of the in-house stock revealed two vials of the IV Zosyn that had been ordered for Resident #78. The LPN further explained if the antibiotic was not in-house, they could call their pharmacy and have a drop ship delivered, explaining it would be delivered in one to two hours.</p> <p>During an interview on 04/04/24 at 10:31 AM, the Unit Manager was unaware of the delay in starting the Zosyn for Resident #78.</p> <p>(continued on next page)</p>		

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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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/04/24 at 10:47 AM, Staff L, LPN, who introduced herself as the Weekend Supervisor, explained she thought Staff N, physician, told Staff M, the Registered Nurse (RN) who took the IV antibiotic order, to finish the oral (pill form) of the previously ordered antibiotics prior to starting the IV. The Weekend Supervisor stated that was why the IV antibiotic was delayed. Upon further review of the record with the Weekend Supervisor, she agreed this was not documented in the record, and the oral form of the antibiotics had just started and were ordered for several days. The Weekend Supervisor sent a text to Staff L, who responded the physician was in the building and told her to continue the oral antibiotics until they received the IV antibiotics from the pharmacy.</p> <p>During a phone interview on 04/04/24 at 11:06 AM, Staff L, LPN stated the physician told her to give the oral antibiotic until the IV antibiotics were delivered from the pharmacy. When asked if she was aware the medication was in the Pyxis, the in-house dispensing system, the nurse stated she was unaware.</p> <p>During a phone interview on 04/04/24 at 11:10 AM, when asked if he was aware of the delay in starting the IV antibiotic for Resident #78, Staff N, physician, stated he thought there was a problem getting the IV started. The physician was informed the IV line (midline) was in place about 2 PM on 03/31/24, and that the resident did not get the 6:00 PM or midnight dose. When asked if this was appropriate or his intent, Staff N, physician, stated he would have liked the IV antibiotic to start as soon as able.</p>