STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105835	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Trail Nursing and Rehab Center	4445 Pine Forest Dr Lake Worth, FL 33463

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interview, and record review, the facility failed to ensure dignity with dining for 2 of 55 sampled residents reviewed for dining, Residents #1 and #14, as eced by standing to feed the resident, assisting one resident later than the roommate and calling the reisdent a feeder. The findings included: 1. Record review for Resident #1 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Alzheimer's Disease, Dementia, Chronic Obstructive Pulmonary Disease, and Major Depressive Disorder, and Nonexudative Age-Related Macular Degeneration Bilateral Early Dry Stage. Review of the Minimum Data Set (MDS) assessment for Resident #1 dated 11/29/24 documented in Section C, a Brief Interview of Mental Status (BIMS) score of 3 indicating severe cognitive impairment. On 12/17/24 at 8:40 AM, an observation was made of Staff L, Certified Nursing Assistant (CNA), who was standing over Resident #1 feeding the resident oatmeal. An interview was conducted on 12/17/24 at 8:44 AM with Staff L who stated she has worked at the facility for about 7 months. When asked if she normally stands over the residents when feeding them, she said no, usually she sits in a chair with the tray in front of her and feeds the resident, but she did not do that today. She said the resident normally feeds herself and when she came to get the breakfast tray, she noticed the resident did not really eat anything, so she offered to feed her, and fed the resident the oatmeal. 2. Record review for Resident #14 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Alzheimer's Disease, Stiffness of Right Hand, Stiffness of Left Hand. Review of the MDS assessment for Resident #14 dated 09/03/24 documented in Section C, a BIMS score could not be completed due to the resident is rarely/never understood. Review of the Physician's Orders for Resident #14 revealed an order dated 07/23/24 for regular diet pureed texture fortified foods. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 12:30 PM, an observation was made of Resident #14's roommate who received lunch tray. On 12/16/24 at 12:35 PM, an observation was made of Resident #14 lunch tray delivered to her room and it was placed on the nightstand near resident who was sitting in Geri chair next to bed. On 12/16/24 at 12:49 PM, an observation was made of a staff member who assisted Resident #14 with feeding, 19 minutes after the roommate received the lunch tray and 14 minutes after her lunch tray was delivered to the resident. An interview was conducted on 12/16/24 at 12:50 PM with Staff C, Licensed Practical Nurse (LPN), who stated she has worked at the facility since March 2024. When asked about the lunch tray for Resident #14, she stated she is a feeder, and we pass the trays last for feeders because they need to be fed.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to ensure residents' accommodation of needs with sufficient staffing to ensure care and services were provided that assured residents maintain the highest practicable physical, mental, and psychosocial well-being as required by the residents' diagnoses or medical condition for 2 of 25 sampled residents, Residents #48 and #52. The findings included: 1. Review of the facility's, Leave of Absence Sign-Out/Sign-In Release of Responsibility, sheet revealed the following: The undersigned, resident or responsible party on behalf of the named Resident, desires to temporarily leave Pine Trail. By signing below, I understand and agree that Pine Trail shall not be liable for any injuries that occur or be subjected to any demand or any claim for injuries or damages, whatsoever that result from any event occurring outside or off of the premises of Pine Trail. Record review for Resident #48 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Major Depressive Disorder (MDD). Review of the Minimum Data Set (MDS) assessment for Resident #48 dated 11/13/24 revealed in Section C, a Brief Interview for Mental Status (BIMS) score of 15 indicating an intact cognitive response. Section GG of the same MDS revealed Resident #48 is independent for all his Activities of Daily Living (ADLs) and able to walk independently. An interview was conducted on12/19/24 at 8:45 AM with Resident #48 who stated he used to be able to go outside in the front of the building to walk around. He was told that he can no longer go outside in the front due to 'insurance reasons', and he could only go walking in front of the building if they had enough staff to send a staff member with him. He then stated they never have enough staff, so he stopped asking to go out front. Resident #48 stated again that he would like to be able to walk in the front of the building because the courtyard feels enclosed, like a 'caged dog'. An interview was conducted on 12/20/24 at 12:00 PM with the Director of Nursing (DON) who stated she has been at the facility for 6 months. She stated residents can leave the facility only if a family member signs them out or the activity staff has a planned activity to go outside of the building. The DON acknowledged that if a resident does ask to go outside of the building, and if she has a staff member available, then the resident is allowed to go outside. The DON stated that for the safety of the resident, they cannot sign themselves out even if they have a BIMS of 15 because the resident might want to cross the street and the facility is responsible for them. Review of Resident #48's Leave of Absence sign out sheet revealed Resident #48 was allowed to walk outside during the month of November 2024 with last day being 11/18/24. A side-by-side review was conducted of the Leave of Absence Sign-out/sign-in Release of Responsibility statement with the DON, who stated that the form would have to be changed because residents are not to go outside without a staff member. (continued on next page)

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	105835	A. Building B. Wing	12/20/2024

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review for Resident #52 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Presence of Cerebrospinal Fluid Drainage Device, Muscle Weakness, Abnormal Posture, and Syncope. Review of Section C of the MDS dated [DATE] revealed Resident #52 had a BIMS score of 14 indicating an intact cognitive response. Review of Section GG of the same MDS revealed Resident #14 requires substantial to maximal assistance for most of his ADLs and partial to moderate assistance for eating. Review of the Care Plan dated 09/28/24 documented Resident #52 is at risk for injury related to falls/related to: Impaired mobility, Requiring assist from at least 1-2 helper for safe transfer. The goal was for Resident #52's risk of fall related injury will be minimized through the next review. The interventions included: Encourage Resident #52 to call for assistance as needed; Observe for and report changes in mobility and/or Range of Motion. Use Mechanical lift for transfers. Floor mats to both side/s of bed when in bed. During observation on a tour conducted on 12/16/24 at 10:10 AM of Resident #52's room, it was noted that Staff H, Certified Nursing Assistant (CNA), was in the room. At 10:21 AM, Staff H was observed walking down the hallway and appeared to be looking for another staff member. At 10:31 AM, Staff H was observed still looking for another staff member and was wheeling the Hoyer lift towards Resident #52's room. At this time, the Director of Admissions was walking down the hallway and assisted Staff H to wheel the Hoyer lift into Resident #52's room and closed the door. At 10:41 AM, the Director of Admissions stepped out of the room and shortly after Staff H came out with the Hoyer lift. An interview was conducted on 12/17/24 at 3:58 PM with Resident # 52 who noted that Monday's dinner (12/16/24) was left on the side table where he could not reach it. He also mentioned he used to get someone to assist him with his meals, but lately they stated that he can feed himself and no one comes by to help him with his meals. He stated that he likes to eat his breakfast and lunch in the dining area, but the staff has been slow to get him out of bed and he sometimes has to eat his meals in his room. An interview was conducted on 12/18/24 at 3:07 PM with Staff H who stated she has worked at facility for 7 years. She stated that a resident that has limited assistance means the resident requires one person to assist with transfer, compared to a resident that is total care assist who requires 2 persons with a Hoyer lift. Staff H stated she set up the resident with the Hoyer pad prior to wheeling the Hoyer lift to the resident's room, and then she gets anyone of the nursing staff, or anyone that is certified to assist with Hoyer lift to transfer the resident. She also stated that it is difficult to get someone to help because everyone is busy trying to get their work done. She acknowledged that on 12/16/24, the admission director offered to help her to transfer Resident #52, and she agreed since she had been looking for another CNA to assist for a while. She stated she believes the facility is short staffed and she is often scheduled to care for 11 total care assist residents and to also assist with meal tray distribution. She recognized she often feels rushed to provide care to her residents. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 12/18/24 at 3:27 PM with the Director of Admissions, who stated he has worked at the facility since August 2024. He stated he has no prior clinical title or certifications, and no Hoyer lift training nor education on how to transfer residents. He acknowledged that he was aware that maybe assisting Staff H with the Hoyer lift was something that he should not be doing, Staff H needed assistance and no one else was available. An interview was conducted on 12/20/24 at 1:33 PM with Staff C, Licensed Practical Nurse (LPN), who stated she has been working at the facility for 9 months. Staff C mentioned she sometimes helps the CNAs to transfer a resident from bed to chair only if the resident is able to assist, but if the resident requires the Hoyer lift, she cannot because it will take too long and she has to finish with medication administration, etc. She stated that in this case she tells the CNA to get another CNA to assist with the transfer. She stated she does feel that the facility is short staffed for CNAs and that the CNAs are often rushed to get their work done.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews, and record review, the facility failed to ensure adequate hot water temperatures for 3 of 31 residents' rooms (Rooms 4, 27 and 28) and 1 of 2 shower rooms reviewed for comfortable temperature levels; failed to ensure 4 of 4 hallways had firmly secured handrails to the walls; failed to ensure the emergency call system cord were long enough and accessible for 5 of 31 resident's bathrooms (Rooms 16, 20, 21, 24, and 27); failed to provide covers for florescent light fixtures located above residents' beds for 60 of 61 beds reviewed for safe, comfortable, homelike environment; and failed to secure residents' personal property and medical records. The findings included: 1. During tour of the facility conducted on 12/16/24 at 10:34 AM of room [ROOM NUMBER] and 28, it was observed that after running the hot water in the bathroom for 2 minutes, it was not hot to the touch. An interview was conducted on 12/16/24 at 10:38 AM with both residents residing in room [ROOM NUMBER] who stated the hot water does run out at times, especially later in the day when the water is just warm. Both residents stated that this has been an issue for about 4 weeks and the staff is aware, but nothing is being done. An interview was conducted on 12/17/24 at 3:58 PM with the resident residing in room [ROOM NUMBER] who stated there's no hot water in the shower room or in his bathroom. He stated he would like weekly showers but the water is too cold, never gets hot, and he does not want a shower. An interview was conducted on 12/17/24 at 1:20 PM with the Maintenance Supervisor, who stated he started working at the facility in September 2024. He stated that he was not aware of any issues with the hot water. At this time, a tour of the rooms was conducted to test the temperature of the water in residents' rooms. The Maintenance Supervisor had his own non-digital thermometer, which he stated he uses to randomly check the water temperatures monthly. The Maintenance Supervisor ran the hot water for 2 minutes in room [ROOM NUMBER]'s bathroom sink, and then placed the thermometer under the running water for 30 seconds, which read 90 degrees Fahrenheit (F). This process was repeated for room [ROOM NUMBER], which the hot water temperature read below 90 F, and again was done for room [ROOM NUMBER] in which the hot water temperature was 92 F. The Maintenance Supervisor stated that he has checked the water temperatures this month and the temperatures were not this low. An interview was conducted on 12/17/24 at 2:00 PM with Staff R, Certified Nursing Assistant (CNA), who stated she has been working at the facility for 4 months. She stated sometimes she must let the hot water run for a while (she was unable to state how long) but if the resident states the water is too cold, she just runs the hot water and will wait until it is warmer. Review of the water temperatures for the month of December (dated 12/09/24) revealed water temperatures were checked in 8 rooms and the shower rooms with the temperatures ranging between 109F and 111F. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 12/17/24 at 2:44 PM with the Maintenance Supervisor and the Environmental Director. The Maintenance Director stated she has part-time and full-time maintenance staff and there is a maintenance binder located at the nurses' station which is checked throughout the day by the maintenance staff. Any staff member can enter a maintenance request, and her staff is to sign off only when the work has been completed or resolved. Review of the maintenance binder (log) located at the nurses' station revealed the following: On 11/11/24, a nurse reported family complained about no hot water in the building and it was signed by maintenance staff as in progress. On 11/12/24, a staff member reported no hot water and it was signed by maintenance staff as parts are on order for repair. On 11/21/24, a CNA reported there is still no hot water pipe runs for 15 minutes still nothing cold as ice and it was signed by maintenance staff as in progress. On 11/23/24, a CNA reported shower room head need fixing, still no hot water and maintenance staff signed as in progress. On 11/27/24, a staff member reported no hot water in the shower room and maintenance staff signed as in progress. An interview was conducted on 12/17/24 at 4:35 PM with the Maintenance Supervisor who stated that on 11/12/24, there was water boiler issue throughout the building (prior he had stated there were no hot water issues), and they tried to figure out the issue themselves, but were not able to and a third-party vendor was called (company name provided). In the meantime, the nursing staff were instructed to run the hot water longer. Review of the [Company]'s invoice dated 12/02/24 revealed the cause for not having hot water in the building for the month of November was due to the high limit was set incorrectly causing heater to turn off before meeting temperatures. An interview was conducted on 12/18/24 at 8:30 AM with the Maintenance Supervisor and the Environmental Director. The Maintenance Supervisor stated that he regulated the boiler yesterday (12/17/24) and the boiler temperature was at 120F. He stated he tested the water temperatures this morning and they are still reading at around 90F. The Environmental Director stated that there's no invoice for ordered parts (from 11/12/24 maintenance log) because the third-party vendor came in on 12/02/24 and stated no need for parts, just the boiler settings were off. She noted a plumber had been called as of Tuesday 12/17/24 to look at the boiler. An interview was conducted on 12/18/24 at 3:07 PM with Staff H, CNA, who stated she has worked at the facility for 7 years. Staff H stated she often feels rushed when providing care to the residents. She noted it takes about 10 minutes to get the water warm enough for the residents and she does not open the cold water. Staff H was observed during catheter care, and she acknowledged that she left the water running for most of the procedure to ensure the water was warm enough. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A hot water temperature test was conducted on 12/20/24 at 10:20 AM of rooms 4, 27,28,12 and shower room (across the nurses' station) with the Maintenance Supervisor and Environmental Director. The hot water temperatures ranged from 84F to 95F. The Environmental Director acknowledged that the boiler supplies hot water for both buildings (the nursing home and another residence building that's attached), and this can be why the water temperatures vary throughout the day. In addition, the Maintenance Supervisor stated the plumbing company came in on 12/19/24 and provided options to get the hot water to the residents that are farthest from the boiler room (rooms [ROOM NUMBERS] hot water temperature read 84F to 90F). 2. Review of the record revealed Resident #43 was admitted to the facility 04/02/24 with the primary diagnosis of Cerebral Infarction (a disruption of blood flow to the brain), and oher diagnoses to include Altered Mental Status, Ahasia (a language disorder that affects how you communicate) and Depression. Review of the care plan dated 04/15/24 documented, Resident #43 has impaired cognition as evidence by cerebral vascular accident, stroke . etc. The goal stated The resident will make appropriate decisions daily related to personal preferences and/or through next review. The intervention documents, Encourage decision making related to personal preference and care with each encounter. An interview was conducted on 12/16/24 at 2:19 PM with Resident #43's representative who voiced that there was not any hot water available when she tried to bathe the resident. She stated the resident did not want to get cleaned because the water was too cold and he preferred hot water. 3. On 12/16/24 from 9:30 AM to 12:00 PM during initial tour of the facility, the handrails next to room [ROOM NUMBER], #10, #14, #18, and #26, were worn and loosely affixed to wall. 4. On 12/16/24 at 8:40 AM, an observation was made in conference room (not labeled as such) with boxes of medical records stored on floor, broken chairs, and various items of clothing, some in bags, some not in bags. Photographic Evidence Obtained. 5. On 12/16/24 at 9:10 AM, an observation was made of the Central Supply Room door being open with Staff P, Medical Record / Central Supply Clerk inside. There were several boxes of supplies stored directly on the floor, some items were on wooden platform type pallets. Photographic Evidence Obtained. Two 2 of the 6 ceiling light fixtures with fluorescent bulbs were not functioning. 6. On 12/17/24 at 8:46 AM, an observation was made of 2 fire doors that lead to hallway with rooms 9-15, propped open and 2 fire doors that lead to hallway with room [ROOM NUMBER]-8 propped open. Photographic Evidence Obtained. 7. An environmental tour was conducted on 12/20/24 at 10:40 AM with the Environmental Director, the Maintenance Supervisor and the Regional Maintenance Director present. The following side-by-side observations were completed with the Environmental Director, the Maintenance Supervisor and the Regional Maintenance Director who acknowledged the identified issues as follows: a. Fluorescent light fixtures behind head of bed was not covered in 60 of the 61 beds (only bed with properly covered fluorescent light fixture was in room [ROOM NUMBER]-A). b. Short emergency cords in 5 of 31 resident bathrooms (rooms #16, #20, #21, #24 and #27). (continued on next page)

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	105835	A. Building B. Wing	12/20/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Call lights located on the floor and not accessible to residents in rooms (1B, and 9B). d. Handrails throughout facility worn and not securely fixed to walls. e. The room next to the social worker office had multiple boxes with medical records (with resident information) stored on floor, broken furniture, used resident clothing and personal items some in bags, some in ripped bags, some just loose and broken and non-functioning fluorescent ceiling lights. Photographic Evidence Obtained. An interview was conducted on 12/16/24 at 9:13 AM with Staff P, Medical Record / Central Supply Clerk, who stated she has worked at the facility for 15 plus years with the old company and 1 year with the new company. When asked about the Central Supply Room, she said it has always been this way. An interview was conducted 12/17/24 at 12:40 PM with the Regional Director of Maintenance who stated the double fire doors should never be propped open, and he told staff that when he walked in today.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interview and record review, the facility failed to report an adverse event for 1 of 1 sampled resident reviewed for a fall with fracture, Resident #32. The findings included: Record review revealed Resident #32 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Unspecified Intracapsular Fracture of left femur, Hypertension, and Major Depression. The documented Brief Interview for Mental Status (BIMS) score, on the significant change Minimum Data Set (MDS) assessment dated [DATE], was 3 indicating severe cognitive impairment. Review of a fall investigation and nursing progress note for 09/23/24 at 6:00 AM documented the resident was found on the floor next to his bed. He was observed laying on his left side. He was unable to give a description of what happened and was showing signs and symptoms of pain to the left hip. He was transferred into bed. The Physician and family were notified and the Physician ordered an x-ray to the left hip. The X-ray results noted an acute left acetabular fracture and the Advance Registered Nurse Practitioner ARNP) was notified and gave an order to send the resident to the emergency room for evaluation. An interview was conducted on 12/18/24 at 10:45 AM with the Director of Nurses (DON) during the side by side review of the unwitnessed fall investigation. The DON stated upon review of the fall during the Interdisciplinary Team (IDT) meeting, it was decided that the fall did not result in a fracture and the fracture was a spontaneous event. There were no in-services done. The surveyor asked for documentation of this meeting and the DON stated they have no documentation. When asked how they determined that the fracture did not result from the fall, she stated they based it on the hospital records. The surveyor asked who else was present at this meeting and she stated it was the Administrator, Social worker, MDS person and Rehab Director. The surveyor asked if the Physician was consulted regarding their conclusion and she replied that he was not. An interview was conducted with Staff F, Rehab Director, on 12/18/24 at 11:16 AM. He stated it was determined it was a pathological fracture due to the hospital notes and he ould find where he read that on the hospital record and provide it to the surveyor. On 12/18/24 at 12:55 PM, he returned and stated he could not find any notes from the hospital that stated it was a pathological fracture. Interview was conducted with the Administrator on 12/18/24 at 12:03 PM who stated she would not report this event because it was a fall, and because it was't an unknown fracture, as they thought they had figured out how it happened (pathological), and she would not do an immediate or day-5 report. She stated she reviewed the regulations and determined it was not reportable. There was no documented evidence that the fracture was pathological or that an immediate or day-5 report was submitted.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on interview and record review, the facility failed to complete a Quarterly Minimum Data Set (MDS) assessment within the regulated time frame for 1 of 2 sampled residents reviewed for resident assessments, Resident #46. The findings included: Record review revealed Resident #46 was admitted to the facility on [DATE]. An admission assessment was done with an assessment reference date (ARD) of 05/05/24. This was followed by a quarterly assessment with an ARD of 08/05/24. The next quarterly assessment was scheduled to be completed for 11/30/24. This assessment was not started on 11/05/24 and not completed as of the time of the interview on 12/17/24. On 12/17/24 at 2:18 PM, an interview was conducted with the Minimum Data Set (MDS) coordinator. She stated she was the only MDS coordinator for the facility but sometimes the regional MDS coordinator will assist her. She was asked about Resident #46's quarterly MDS assessment as it was marked late under the resident assessment facility task. A quarterly assessment is timely if it is completed within 92 days of the previous assessment. November 5 would have been 92 days after the previous assessment. The MDS coordinator stated she was swamped and out sick for a few days and no one fills in for her. She opened the assessment and it was on her calendar to do the assessment. She stated she thought she had 30 more days to complete the assessment. When asked to provide that information to the surveyor, she stated when she found it she would. The information was not provided. She stated she has been doing MDS's since 2013 and has been working in this facility since June or July 2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105835	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Trail Nursing and Rehab Center	4445 Pine Forest Dr Lake Worth, FL 33463

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on interview and record review, the facility failed to ensure services provided, that included Administration of Intravenous [IV] medication, met professional standard of quality for 4 Licensed Practical Nurses (LPNs) employed by the facility for 1 of 1 sampled resident with a Peripherally Inserted Central Catheter (PICC), Resident #365. The findings included: Review of the Florida Board of Nursing located at the web address: https://floridasnursing.gov/administration-of-intravenous-therapy-by-licensed-practical-nurses/ Included in part the following: CHAPTER 64B9-12 ADMINISTRATION OF INTRAVENOUS THERAPY BY LICENSED PRACTICAL NURSES 64B9-12.005 Competency and Knowledge Requirements Necessary to Qualify the LPN to Administer IV Therapy. (1) The course necessary to qualify a licensed practical nurse or graduate practical nurse to administer IV therapy shall be not less than a thirty (30) hour post-graduation level course teaching aspects of IV therapy. The didactic intravenous therapy education must contain the following components: (a) Policies and procedures of both the Nurse Practice Act and the employing agency in regard to intravenous therapy. This includes legalities of both the Licensed Practical Nurse role and the administration of safe care. Principles of charting are also included. (b) Psychological preparation and support for the patient receiving IV therapy as well as the appropriate family members/significant others. (c) Site and function of the peripheral veins used for venipuncture. (d) Procedure for venipuncture, including physical and psychological preparation, site selection, skin preparation, palpation of veins, and collection of equipment. (e) Relationship between intravenous therapy and the body's homeostatic and regulatory functions, with attention to the clinical manifestations of fluid and electrolyte imbalance. (f) Signs and symptoms of local and systemic complications in the delivery of fluids and medications and the preventive and treatment measures for these complications. (g) Identification of various types of equipment used in administering intravenous therapy with content related to criteria for use of each and means of troubleshooting for malfunction. (h) Formulas used to calculate fluid and drug administration rate. (continued on next page)

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	105835	A. Building B. Wing	12/20/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(i) Methods of administering drugs intravenously and advantages and disadvantages of each. (j) Principles of compatibility and incompatibility of drugs and solutions. (k) Nursing management of the patient receiving drug therapy, including principles of chemotherapy, protocols, actions, and side effects. (l) Nursing management of the patient receiving blood and blood components, following institutional protocol. Include indications and contraindications for use; identification of adverse reactions. (m) Nursing management of the patient receiving parenteral nutrition, including principles of metabolism, potential complications, and physical and psychological measures to ensure the desired therapeutic effect. (n) Principles of infection control in IV therapy, including aseptic technique and prevention and treatment of iatrogenic infection. (o) Nursing management of special IV therapy procedures that are commonly used in the clinical setting, such as heparin lock, central lines, and arterial lines. (p) Glossary of common terminology pertinent to IV fluid therapy. (q) Performance check list by which to evaluate clinical application of knowledge and skills. (2) Clinical Competence. The course must be followed by supervised clinical practice in intravenous therapy to demonstrate clinical competence. Verification of clinical competence shall be the responsibility of each institution employing a Licensed Practical Nurse based on institutional protocol. Such verification shall be given through a signed statement of a Licensed Registered Nurse. (3) Central Venous Lines (CVL) and Peripherally Inserted Central Catheter (PICC) Lines. The Board recognizes that through appropriate education and training, a Licensed Practical Nurse is capable of performing intravenous therapy via central and PICC lines under the direction of a registered nurse or other health care practitioner as defined in subsection 64B9-12.002, F.A.C. Appropriate education and training requires a minimum of four (4) hours of instruction. The requisite four (4) hours of instruction may be included as part of the thirty (30) hours required for intravenous therapy education specified in subsection (4) of this rule. The education and training required in this subsection shall include, at a minimum, didactic and clinical practicum instruction in the following areas: (a) Central venous anatomy and physiology; (b) CVL and PICC site assessment; (c) CVL and PICC dressing and cap changes; (d) CVL and PICC flushing; (e) CVL and PICC medication and fluid administration; (continued on next page)

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	105835	A. Building B. Wing	12/20/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(f) CVL and PICC blood drawing; and, (g) CVL and PICC complications and remedial measures. Upon completion of the intravenous therapy training via central and PICC lines, the Licensed Practical Nurse shall be assessed on both theoretical knowledge and practice, as well as clinical practice and competence. The clinical practice assessment must be witnessed by a Registered Nurse who shall file a proficiency statement regarding the Licensed Practical Nurse's ability to perform intravenous therapy via central lines. The proficiency statement shall be kept in the Licensed Practical Nurse's personnel file. Record review revealed Resident #365 was admitted to the facility on [DATE] with diagnoses that included Fracture of Neck, Pneumonitis and Dysphagia. The resident was admitted with a PICC (peripherally inserted central catheter) line in place. Review of Resident #365's December 2024 Medication Administration Record (MAR), specifically from 12/09/24-12/15/24 revealed Vancomycin Intravenous Solution Reconstituted 1.5 GM (gram) Use 1500 mg (milligrams) intravenously two times a day for aspiration pneumonia, was administered by a Licensed Practical Nurse (LPN). The record showed the following: On 12/09/24 at 6:00 AM, Staff A, LPN, administered the IV medication; On 12/10/24 Staff C, LPN, administered the IV medication at 6:00 PM; On 12/11/24 and 12/12/24, Staff A again administered the IV medication at 6:00 AM; On 12/13/24 and 12/14/24, Staff D, LPN, administered the IV medication at 6:00 AM; On 12/15/24, Staff B, LPN, administered the IV medication at 6:00 AM. On 12/18/24 at 9:34 AM a telephone call was placed to Staff A, LPN, to question her IV certification. On 12/18/24 at 9:34 AM, a telephone call was placed to Staff A, LPN, to question her IV certification. A phone message was left for her to return the surveyor's call but it was never returned. On 12/18/24 at 2:24 PM, the Human Resources Director was asked to provide the IV certification for the LPNs in the facility. During a review of the personnel files for Staff A, Staff B, Staff C and Staff D, all LPNs, it was determined there was no IV Certification for each of the LPNs. On 12/19/24 at 10:00 AM, an interview was conducted with the Director of Nurses (DON). She was asked if she was aware that 4 LPNs who were administering IV medications to Resident #365 were not IV certified. She stated she just became aware of this.

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	105835	A. Building B. Wing	12/20/2024

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interview and record review, the facility failed to ensure adequate supervision and assistive devices to prevent accidents and injuries, and ensure a safe environment, failed to ensure a complete investigation and follow up were completed for 1 of 2 sampled residents reviewed for falls, Resident #32. The findings included: Record review revealed Resident #32 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included Unspecified Intracapsular Fracture of left femur, Hypertension, and Major Depression. The significant change Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. Review of a fall investigation and nursing progress note dated 09/23/24 at 6:00 AM revealed the resident was found on the floor next to his bed. The resident was observed laying on his left side. He was unable to give a description of what happened and was showing signs and symptoms of pain to the left hip. He was transferred into bed. The Physician and family were notified and the Physician ordered an x-ray to the left hip. The X-ray results noted an acute left acetabular fracture and the Advanced Registered Nurse Practitioner (ARNP) was notified and gave an order to send the resident to the emergency room for evaluation. An interview was conducted on 12/18/24 at 10:45 AM with the Director of Nurses (DON) during the side-by-side review of the unwitnessed fall investigation. The DON was asked what the resident was doing prior to the fall, what he was wearing, when was the last time he received care, were fall mats by the bed at the time of the incident, what was the position of the bed, and were there witness statements. The DON then produced two witness statements: A statement from the nurse who was present and the CNA (certified nursing assistant) who found him. The fall investigation did not include that the resident was found to have a fracture or any follow up in-services done with the staff or any care plan updates. The DON stated upon review of the fall during the Interdisciplinary team (IDT) meeting, it was decided that the fall did not result in a fracture and the fracture was a spontaneous event (a pathological fracture). There were no in-services done. The surveyor asked for documentation of this meeting and the DON stated they have no documentation. When asked how they determined that the fracture did not result from the fall, she stated they based it on the hospital records. The surveyor asked who else was present at this meeting and she stated it was the Administrator, Social worker, Minimum Data Set (MDS) person and Rehab Director. An interview was conducted with Staff F, Rehab Director, on 12/18/24 at 11:16 AM. He stated it was determined it was a pathological fracture due to the hospital notes and he would find where he read that on the hospital record and provide it to the surveyor. On 12/18/24 at 12:55 PM, he returned and stated he could not find any notes from the hospital that stated it was a pathological fracture. (continued on next page)

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	105835	A. Building B. Wing	12/20/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the care plans for Resident #32 revealed a care plan for at risk for injury related to falls related to recent fall, history of falls, history / recent fall with fracture, impaired mobility, poor balance, poor safety awareness, doesn't recognize limitations, antidepressant medications, anticoagulant / antiplatelet use, respiratory status increases risk. The care included the following updates: 06/25/24, status post (s/p) fall no injury 06/28/24, s/p fall no injury 09/23/24, s/p fall 09/30/24, readmit with left femur fracture This care plan was initiated on 06/26/24 and revised on 12/17/24. Interventions included: 09/23/24, Resident transferred to hospital date initiated 09/23/24. 09/23/24, x-ray to left hip date initiated 09/23/24. Remind/encourage Mr . to call for assistance when needed date initiated 06/28/24. Call bell in reach date initiated 06/26/24. 06/25/24, therapy referral / evaluation / treatment as indicated date initiated and revised 06/26/24. 06/28/24, remind / encourage to call for assistance as needed date initiated 06/28/24 and revised 08/22/24. Assist as needed with transfer / ambulation date initiated 06/26/24. Transfer/gait belt for transfers and/or ambulation date initiated 06/26/24. Ensure proper foot wear worn date initiated 06/26/24. (3/4, 1/2, 1/4) Side rails to promote independence in bed mobility date initiated 06/26/24. Bed in low position date initiated 06/26/24. Bed/chair alarm as ordered date initiated 06/26/24. Observe for a report changes in mobility and/or range of motion date initiated 06/26/24. Remind / encourage use of glasses date initiated 06/26/24. (continued on next page)

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	105835	A. Building B. Wing	12/20/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R/O [rule out] falls with bruising of unknown origin or new complaint of pain date initiated 06/26/24. Room change as indicated date initiated 06/26/24. Use mechanical lift for transfers date initiated 06/26/24. Floor mats to both side/s of bed when in bed date initiated 06/26/24 and revised 08/22/24. Review of the fall investigation revealed no indication as to whether or not floor mats were in place. There were no new interventions on the care plan post fall with fracture on 09/23/24. An interview was conducted with the Administrator on 12/18/24 at 12:03 PM who stated she would not report this event because it was a fall and because it wasn't determined to be unknown (pathological) as they figured out how it happened, and she would not do an immediate or 5 day report. On 12/18/24 at 3:35 PM, an observation of the resident's room revealed no floor mats were in the resident's room. An interview conducted with Staff E, Certified Nursing Assistant, CNA, who worked in the facility for 8 years, revealed she did not recall ever seeing floor mats by his bed or in his room. On 12/19/24 at 9:00 AM, observation was made of the resident in bed with no floor mats beside the bed.

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	105835	A. Building B. Wing	12/20/2024

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interviews, and record review, the facility failed to maintain a Peripherally Inserted Central Catheter (PICC) line in a sanitary manner for 1 of 1 sampled resident reviewed for PICC lines, Resident #365. The findings included: Record review revealed Resident #365 was admitted to the facility on [DATE] with diagnoses that included Fracture of Neck, Pneumonitis and Dysphagia. He was admitted to the facility with a PICC line. On 12/18/24 at 8:19 AM, Resident #365 was observed in bed eating breakfast. The surveyor observed the PICC line dressing exposed on his right arm. The dressing was dated 11/27/24. The resident was admitted to the facility on [DATE] revealing the dressing change was not changed since the resident has been admitted to the facility. Photographic Evidence Obtained. Review of the Physician order for the PICC line dressing change was ordered on 11/29/24, Change IV (intravenous)PICC line dressing to right arm every night shift every Tuesday. Review of the December 2024 Treatment Administration Record (TAR) for Resident #365 revealed it was initialed by Staff A, Licensed Practical Nurse (LPN), as being changed on 12/03/24, 12/10/24 and 12/17/24. On 12/18/24 at 9:34 AM, a telephone call was placed to Staff A, LPN, to question her IV certification and what she did when she marked the dressing change as being completed for the dates noted above. A message was left for her to return the surveyor's call, but it was never returned. On 12/18/24 at 10:20 AM, it was discussed with the Director of Nurses (DON) that Staff A signed off on changing the dressing for the PICC line and a telephone message was left to the LPN. The DON was shown the photo of the PICC line with the 11/27/24 date and she acknowledged that it was not changed. She stated that there was no policy for dressing change for the PICC line and they follow doctors orders.

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	105835	A. Building B. Wing	12/20/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51137 Based on observation, interview, and record review, the facility failed to provide an assessment before and after respiratory care for 1 of 7 sampled residents observed during medication administration, Resident #365. The findings included: Record review revealed Resident #365 was admitted [DATE] with the primary diagnosis of unspecified Fracture of the Neck. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #365 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 active orders documented: Ipratropium-Albuterol inhalation solution every 6 hours as needed for shortness of breath and/or wheezing. Nebulizer: Assess prior to administering Nebulizer Treatment Document Lung Sounds as 1=Clear 2=Rales 3=Congested 4=Crackles 5=Rhonci 6=Rubs 7=Wheezing 8=Diminished every 6 hours for monitoring. Nebulizer: Assess after administering Nebulizer Treatment Document Lung Sounds as 1=Clear 2=Rales 3=Congested 4=Crackles 5=Rhonci 6=Rubs 7=Wheezing 8=Diminished every 6 hours for monitoring. During a medication administration observation on 12/19/24 at 9:41 AM, Resident #365 was scheduled to receive Metoprolol 50 mg (a cardiac and blood pressure medication) along with other oral medications and the Ipratropium-Albuterol inhalation solution, (a nebulizer treatment). Staff Q, Registered Nurse (RN), checked the blood pressure and heart rate of the resident and administered the Metoprolol pills along with the rest of the oral medications. Staff Q then administered the nebulizer treatment without providing a pre or post respiratory assessment. During an interview on 12/19/24 at 10:20 AM, when asked how the resident was assessed during the respiratory treatment, Staff Q stated he just administered it because it was scheduled. When asked what that had to do with performing a respiratory assessment, he stated he could have obtained an oxygenation saturation reading and listened to the resident's lungs. When asked why he did not perform that he stated that he normally does but he forgot. An interview was conducted with the Nursing Home Administrator (NHA) on 12/19/24 11:36 AM who when asked to provide the policy for respiratory care and nebulizer administration, she stated that they did not have a policy for that, they refer to the nebulizer competencies for guidance. The nebulizer administration competency for Staff Q was reviewed. Photographic Evidence Obtained. The NHA was made aware of the medication administration observation findings and agreed that Staff Q should have assessed the resident prior to and after the administration of Resident #365's nebulizer treatment. (continued on next page)

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	105835	A. Building B. Wing	12/20/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Staff Q's competency, titled, Skills Competency Assessment: Nebulizer 10/2021, dated 09/14/24, documented, The employee demonstrates skills and competencies in the following: . 8. Evaluate the resident. Establish baseline respiratory rate, pulse, oxygen saturation and breathe sounds. 15. Evaluate the resident's response and effectiveness of treatment by evaluating breath sounds, pulse rate, oxygenation saturation and respiratory rate.

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	105835	A. Building B. Wing	12/20/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on interviews and record reviews, the facility failed to ensure adequate monitoring of side effects and behaviors for residents receiving psychotropic medications for 5 of 5 sampled residents reviewed for unnecessary medications, Residents #11, #48, #32, #6, #5. The findings included: 1. Record review for Resident #6 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Cerebral Palsy, Epilepsy Unspecified Intractable With Status Epilepticus, Unspecified Intellectual Disabilities, Type 2 Diabetes, Other Lack of Coordination, and Generalized Anxiety Disorder. Review of the Minimum Data Set (MDS) assessment for Resident #6 dated 10/30/24 documented in Section C, a Brief Interview of Mental Status (BIMS) score of 15 indicating an intact cognitive response. Review of the Care Plan for Resident #6 dated 08/08/24 with a focus on the resident has high-Risk medication use: Antidepressants, Hypoglycemics, Diuretics, Antianxiety, Anticoagulants, Antiplatelet. The goals were for the resident to be on lowest therapeutic dose of psychotropic medications and to be free from undesired side effects related to therapeutic use of High- Risk Medications through next review. The interventions included in part the following: Report changes in mood/behavior/effect as needed. Observe for and report side effects of psychotropic medications: Drowsiness, Dizziness, Rapid heartbeat, low blood pressure, changes in vision Constipation, rash, Sensitivity to sunlight. Review of the physician's orders for Resident #6 revealed an order dated 05/30/24 for Amitriptyline HCl Oral Tablet 75 MG Give 1 tablet by mouth at bedtime for depression. Review of the physician's orders for Resident #6 revealed an order dated 11/19/24 for Buspirone HCl Oral Tablet Give 10 mg by mouth three times a day for Anxiety. Review of the physician's orders for Resident #6 revealed an order dated 04/23/24 to observe closely for significant side effects of Anti-Anxiety medication including drowsiness, slurred speech, dizziness, nausea, aggressive or impulsive behavior every shift Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. Review of the physician's orders for Resident #6 revealed an order dated 04/23/24 to observe closely for significant side effects of Anti-Depressant medication including drowsiness, blurred vision, dizziness, nausea, fatigue, trouble sleeping, dry mouth, hallucinations, other unusual changes in mood or behavior every shift Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. (continued on next page)

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	105835	A. Building B. Wing	12/20/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders for Resident #6 revealed an order dated 09/12/24 to Monitor for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care Q [every] shift every shift Document: 'Y' if monitored and none of the above observed or 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. Review of the Medication Administration Record (MAR) for Resident #6 from 12/09/24 to 12/16/24 documented the following: monitoring of behaviors had a check mark (not a Y or N) for each shift for each day. Review of the Treatment Administration Record (MAR) for Resident #6 from 12/09/24 to 12/16/24 documented the following: -monitoring side effects of anti-anxiety medication documented a NO for each shift each day. -monitoring side effects of anti-depressant medication documented a NO for each shift each day with exception to the night shift on 12/12/24 which had no documentation Review of the Progress Notes for Resident #6 from 12/09/24 to 12/16/24 had no documentation of behaviors or side effects. An interview was conducted on 12/18/24 at 10:25 AM with Staff K, Registered Nurse (RN), who stated she has worked at the facility for 3 to 4 months. When asked if a resident is prescribed psychotropic medication such as an antianxiety medication and do they monitor for side effect, she said yes. When asked if same resident has antianxiety medication and how they monitor for behaviors, she said yes. When asked how the behavior monitoring is documented, she stated it would be on the MAR, you check yes if they have behaviors and then document the behavior in the progress note what the behavior was. When asked if they provide interventions and if so where is that documented, she said they provide interventions and sometimes they document the interventions in the progress notes. When asked about documenting the monitoring for side effects, she said that also would be documented on the MAR, as yes or no, yes indicating they are having side effects and no indicating no side effects. When asked if they document the actual side effect, she said no they do not document that in the progress notes. If you have no behaviors observed you document yes, and if they have behaviors observed you document no. An interview was conducted on 12/18/24 at 10:39 AM with Staff O, Registered Nurse (RN), who stated she has been working at the facility since April 2024. When asked if a resident is receiving a psychotropic medication such as an antianxiety medication do they monitor for behaviors and side effects, she said yes. When asked where the behaviors and side effects are documented, she stated they are documented on TAR, and if you click yes then you write what side effect behavior is observed in the progress note. Interventions should be documented in the progress note as well. When asked about Resident #6, she acknowledged the documentation for side effects and behaviors was not documented appropriately. (continued on next page)

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	105835	A. Building B. Wing	12/20/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 12/18/24 at 10:53 AM with the Director of Nursing (DON) who stated she has worked at the facility for 6 months. When asked about residents receiving psychotropic medication if they are monitored for behaviors and/or side effects, she stated yes, and it would be documented on the MAR and in the progress note if any side effect(s) or behavior(s) were observed. She said she knows that not all nurses document in progress notes for side effects or behaviors. When asked about the documentation she said if the resident has side effects or behaviors observed the nurse should document y for yes. If the resident is not having behaviors, the nurse should document n or no for no behaviors or side effects observed. When asked about Resident #6, the DON acknowledged the documentation for side effects and behaviors was not documented appropriately. 39026 2. Record review revealed Resident #32 was admitted to the facility on [DATE] with diagnoses that included Hypertension, Depression, and Hypothyroidism. The resident was prescribed Sertraline HCl Tablet 50 MG (milligrams) Give 0.5 tablet by mouth one time a day for Depression Give 25 mg; 0.5 tablet equals 25 mg. Review of the current Medication Administration Record (MAR) for December 2024 revealed there were no behavior monitoring documentations as specified in the order which documents, Monitor for the following behaviors (specify): itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care every shift for monitoring. Observe closely for significant side effects of Anti-Depressant medication including drowsiness, blurred vision, dizziness, nausea, fatigue, trouble sleeping, dry mouth, hallucinations, other changes in mood or behavior every shift. Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes'. The MAR revealed check marks twice a day without any indication of what the check marks meant. 49060 3. Record review for Resident #11 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Alzheimer's Disease, Dementia, Psychosis, Major Depressive Disorder (MDD), Anxiety Disorder, and Mood [Affective] Disorder. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had a BIMS of 00, which indicated he was rarely or never understood. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders showed Resident #11 had an order dated 09/11/24 for Depakote Delayed Release tablet 500 mg, give 500 mg by mouth every 12 hours for mood disorder. Monitor for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care every shift; every shift Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. Review of the pPhysician's orders showed Resident #11 had an order dated 09/13/24 for Gabapentin Oral Capsule 100 mg, give 1 capsule by mouth two times a day for Anxiety/Agitation. Observe closely for significant side effects of Anti-Anxiety medication including drowsiness, slurred speech, dizziness, nausea, aggressive or impulsive behavior, every shift Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. Review of the physician's orders showed Resident #11 had an order dated 09/26/24 for Mirtazapine Oral Tablet 7.5 mg, give 7.5 mg by mouth at bedtime for MDD. Observe closely for significant side effects of Anti-Depressant medication including drowsiness, blurred vision, dizziness, nausea, fatigue, trouble sleeping, dry mouth, hallucinations, other unusual changes in mood or behavior; every shift Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. Review of the Care Plan dated 07/31/24 documented Resident #11 has High-Risk medication use: Secondary to Diagnosis / Indication for use of: Antidepressants, Diuretics, Antianxiety. The goals were to have appropriate clinical indicators for use for all High-Risk Medication through the next review. The interventions included: Meds/Labs as ordered. Ensure appropriate clinical indication for use. Drug Regimen Review per facility protocol. Pharmacy reviews per regulation / policy. Report changes in mood/behavior/affect as needed. Observe for and report side effects of psychotropic medications: Drowsiness, Dizziness, Rapid heartbeat, low BP, changes in vision Constipation, rash, Sensitivity to sunlight. Review of the behavior notes and health status notes for Resident #11 for the month of December 2024 revealed no notes related to behaviors or symptoms. Review of the Behavior Monitoring Record and side effects monitoring for Resident #11 from 12/10/24 to 12/18/24 revealed only a check mark each day on each shift (morning and night) for each of the psychotropic medications. The documentation did not indicate a Y or N as ordered. Review of the Psych consultation note dated 11/27/24 documented: Resident #11 is uncooperative with interview and is alert but is confused and does not answer questions appropriately. Discussion held with staff who report no changes in patient's behavior they report that the patient continues to wander mainly at night and that he remains a high fall risk. Plan of care: continue psychotropics as ordered. Continue to monitor and accurately document changes in mood, behavior, and presence of psychiatric symptoms. 4. Record review for Resident #48 revealed the resident was admitted to the facility on [DATE] with diagnoses including: Major Depressive Disorder (MDD) and Acquired Absence of Left Foot. (continued on next page)

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	105835	A. Building B. Wing	12/20/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment for Resident #48 dated 11/13/24 revealed in Section C, a BIMS score of 15 indicating an intact cognitive response. Review of the physician's orders showed Resident #48 had an order dated 05/17/24 for trazodone HCl oral tablet 50 mg, give 100 mg by mouth at bedtime for MDD. Review of the physician's orders showed Resident #48 had an order dated 09/13/24 for Bupropion Hydrobromide Extended Release 24-hour oral tablet, give 150 mg by mouth one time a day related to MDD. Review of the physician's orders showed Resident #48 had an order dated 05/08/24 for Observe closely for significant side effects of Anti-Depressant medication including drowsiness, blurred vision, dizziness, nausea, fatigue, trouble sleeping, dry mouth, hallucinations, other unusual changes in mood or behavior every shift Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. Review of the physician's orders showed Resident #48 had an order dated 09/12/24 for Monitor for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care Q shift every shift Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. Review of the behavior notes and health status notes for Resident #48 for the month of December 2024 revealed no notes related to behaviors or symptoms. Review of the Behavior Monitoring Record and side effects monitoring for Resident #48 from 12/10/24 to 12/18/24 revealed only a check mark each day on each shift (morning and night) for each of the psychotropic medications. The documentation did not indicate a Y or N as ordered. Review of the Psych consultation note dated 10/09/24: The purpose of today was the discussion of a gradual dose reduction (GDR). Various staff members from the facility were present, such as the Director of Nursing (DON) to discuss various behaviors shown by the patient or concerns from staff. Staff report resident is stable, but he has been exhibiting drug seeking behaviors as of recently. Resident recently also started smoking cigarettes. Based on the patient's history and current behaviors it appears that the patient will be unable to tolerate GDR at this moment due to the potential of becoming unstable from a psychiatry standpoint if medication dosages are reduced. Plan of care: Continue psychotropics as ordered. Monitor and document accurately changes in mood, behaviors, or presence of psychiatric symptoms. 51137 5. Review of the record revealed Resident #5 was initially admitted to the facility on [DATE] and readmitted on [DATE] after a hospitalization from a fall in the facility. She was admitted a primary diagnosis of unspecified dementia with other behavioral disturbances. Other diagnoses included: generalized anxiety disorder, recurrent depressive disorders, major depressive disorders, history of falling and unspecified psychosis not due to a substance or known physiological condition. (continued on next page)

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	105835	A. Building B. Wing	12/20/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #5 had a Brief Interview for Mental Status (BIMS) score of 0, on a 0 to 15 scale, indicating the resident had severe cognitive impairment. This same MDS also documented the resident received anti-psychotic, anti-anxiety, anti-depressant medications. Review of the current Treatment Administration Record (TAR) for December 2024, revealed that there wasn't any behavior monitoring documentation as specified in the order. The order documents, Observe closely for side effects of Antipsychotic medication including dry mouth, constipation, blurred vision, disorientation or confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea or vomiting, lethargy, drooling, EPS symptoms (tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue) every shift. Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes'. Upon further review, there was not any behaviors monitored for anti-depressant and anti-anxiety medication administered to Resident #5. Review of the progress notes did not reveal any additional monitoring as ordered. Review of Resident #5's care plan dated 06/18/24 revealed: Focus Resident has High-Risk medication use: Secondary to DX of Anxiety, Depression for use of: Antidepressants, Antianxiety Goal Will have appropriate clinical indicators for use for all High-Risk Medication through next review. Interventions o Report changes in mood/behavior/affect as needed o Observe for and report side effects of psychotropic medications: Drowsiness, Dizziness, Rapid heartbeat, low blood pressure, changes in vision Constipation, rash, Sensitivity to sunlight.

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	105835	A. Building B. Wing	12/20/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to ensure residents are free of significant medication errors for 1 of 7 sampled residents reviewed during medication administration, Resident #42. The findings included: Review of the facility's policy, titled, Medication Administration Policy - General, dated 08/07/23, included the following: Procedure: 3. Dose Preparation: take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 3.7 Verify that the medication name and dose are correct when compared to the medication order on the medication administration record. 4. Verify each time a medication is administered that it is the correct medication, at the current dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as ser forth in facility's medication administration schedule. 4.1 Confirm that the MAR reflects the most recent medication order. Record review for Resident #42 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Cerebral Infarction, Diabetes Mellitus, Hypertension and Cardiomegaly. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #42 had a Brief Interview for Mental Status (BIMS) of 15, indicating an intact cognitive response. A medication administration observation was conducted on 12/17/24 at 8:10 AM with the Assistant Director of Nursing (ADON) and Unit Manager for Resident #42. Resident #42's Blood Pressure (BP) measured 101/80 and HR measured 60. The ADON dispensed the following 7 medications: 1. Aspirin oral tablet 81 mg chewable, give 81mg one time a day for PAD. 2. Eliquis oral tablet 5 mg, give 1 tablet two times a day for cerebral infarction. 3. Gabapentin oral capsule 400mg, give 1 capsule three times a day for Neuropathy. 4. Carvedilol oral tablet 12.5 mg, give 1 tablet every 12 hours for Hypertension, Hold for SBP less than 110 or HR less than 60 (ADON stated she would hold this medication because Resident #42's SBP was 101). 5. Sertraline HCL oral tablet 50mg, give 75mg (1.5 tablet) one time a day for Depression. (continued on next page)

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	105835	A. Building B. Wing	12/20/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Metformin HCL oral tablet 500mg, give 1 tablet two times a day for Diabetes. 7. Nifedipine tablet Extended Release (ER) 24 Hour 60 mg, give 1 tablet by mouth one time a day for hypertension Hold for SBP less than 110 and Heart Rate (HR) less than 60. Reconciliation of Resident #42's physician's orders with the medications administered above revealed Resident #42 had an order for Nifedipine tablet ER 24 Hour 90 mg, to Hold for SBP less than 110 (dated 12/14/24), instead of the Nifedipine ER 24-hour 60 mg that was administered during the medication pass observation. Further review of the physician's orders showed Resident #42 had an order dated 11/21/24 and was discontinued on 12/13/24 for Nifedipine tablet ER 24 Hour 60 mg. As per current order of Nifedipine, Resident #42 should have not received the medication since his SBP was 101, which is outside of the parameters. An interview was conducted on 12/17/24 at 12:10 PM with ADON who stated she has worked at the facility since April 2024. The ADON was asked to review the Nifedipine punch card for Resident #42. A side-by-side review of the punch card for Nifedipine was conducted with ADON which revealed the dose was 60 mg instead of 90 mg. The ADON confirmed there was no other punch card for Nifedipine for Resident #42 in the medication cart. The ADON reviewed Resident #42's Medication Administration Record (MAR) revealing an active order for Nifedipine 90 mg to hold for SBP less than 110 (Resident #42's SBP was 101). Further review and interview with the ADON confirmed the order for Nifedipine 60 mg for Resident #42 was discontinued on 12/13/24. She stated she was not sure what happened and why the discontinued medication was not removed and the new order was not received. She acknowledged that she would monitor the resident for any side effects of receiving Nifedipine since Resident #42's SBP was outside of the parameters. An interview was conducted on 12/17/24 at 12:34 PM with Resident #42 who stated he is feeling okay so far. An interview was conducted on 12/17/24 at 3:02 PM with the Consultant Pharmacist. She stated the Nurse Practitioner (ARNP) changed the Nifedipine order on 12/13/24 at 9:35 AM to 90 mg and sent it to the wrong pharmacy, not to the correct [name provided] Pharmacy, so the order was placed under profile only; therefore, the Nifedipine 90 mg punch card was not sent to the facility. She stated Resident #42's physician has been contacted and the order has been changed back to 60 mg since his BP was 101/80 today. She also stated Resident #42 has been monitored for any side effects. She acknowledged that she is not sure why the nurses did not notice the change in dose and continued to document under the Nifedipine 90 mg order in the MAR. An interview was conducted on 12/18/24 at 10:27 AM with the Director of Nursing (DON), who stated she has been working at the facility for 6 months. She stated that the ADON and herself review any new medication orders as well as discontinued orders throughout the day. She would remove any discontinued medications from the medication carts, or the floor nurse is made aware, and they would remove the medication punch card and store it in the medication room to be send to the pharmacy. The DON acknowledged the nurses continued to document in Resident #42's MAR as administering the Nifedipine 90 mg, but not noticing that the Nifedipine punch card was for 60 mg and this caused the medication error.

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	105835	A. Building B. Wing	12/20/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41837 Based on observations, record review and interview, the facility failed to follow the regular diet menus, affecting 53 of 55 residents receiving a regular diet. The findings included: Review of the facility's menu, titled, Pine Trail Menu F/W 24/25 Week at a Glance for Regular/Regular Week 1, listed Monday (Day 2) lunch as open face hot turkey sandwich, poultry gravy, garlic mashed potatoes, California blend vegetables, pineapple tidbits, bread for open-face sandwich, coffee/tea, and condiments; and listed Wednesday (Day 3) lunch as beef cubed steak with onion gravy, scalloped potatoes, buttered carrots, chocolate chip cookie, dinner roll, margarine, coffee/tea and condiments. Review of the facility menu, titled, 7 Day Hot Weather/Cold Food Menu Week 1, listed Day 2 lunch as egg salad sandwich, marinated beet and onion salad, fruit mix, sandwich bread, coffee/tea, and condiments; and listed Day 4 lunch as tuna salad sandwich, three bean salad, chilled pears, sandwich bread, coffee/tea and condiments. On 12/16/24 (Monday) at 11:20 AM, the facility served sliced turkey on bread with cooked carrots, and pineapple tidbits. On 12/18/24 (Wednesday) at 11:35 AM, the facility served pasta (hot) with meat and tomato sauce containing sausage (hot) with cooked sliced carrots and peas with sliced peaches. An interview was conducted on 12/16/24 at 11:30 AM with the Certified Dietary Manager who was asked why they are not following the Pine Trail Menu F/W 24/25 Week at a Glance for Regular/Regular Week 1. She stated, because they have no working oven, so the company that makes up their menus supplied them with a 7 Day Hot Weather/Cold Food Menu Week 1 that they have been using since before Thanksgiving (11/28/24), but she would substitute the cold vegetable with a hot vegetable so that the residents will get at least one thing hot with each meal. When asked to clarify if it is the same weekly menu each week since before Thanksgiving, she said yes. When asked why they did not serve the egg salad sandwich today, she stated they did not have enough leftover eggs from the previous day's breakfast to make the egg salad, so she substituted the protein with the sliced turkey. When asked how many ounces of sliced turkey is provided for each resident, she said it was 2-ounces. When asked for a scale to measure the sliced turkey on a plate, she stated they do not have a scale, and they just estimate the portion of the turkey. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 12/18/24 at 11:38 AM with the Certified Dietary Manager who was asked why they were not following the '7 Day Hot Weather/Cold Food Menu Week 1' today for Wednesday (Day 4). She stated, because they had to throw refrigerated and frozen food away yesterday due to the refrigerator and freezer not working properly, she improvised with making a pasta and meat and tomato sauce (hot). When asked what menu she followed, she said she did not follow a menu but was sure she could locate one to provide to surveyor. When asked what meat was used in the meat and tomato sauce, she stated it was sausage. When asked what the residents were served for breakfast, she stated sausage, then added we had to use it up before it went bad. An interview was conducted on 12/20/24 at 1:50 PM with the Certified Dietary Manager (CDM) who was asked what was being provided for lunch today. She stated a 2-ounce slice of ham, a 1-ounce slice of cheese 2 slices of bread and mashed potatoes and vegetable. When asked how, if the ham was presliced, she said they sliced it, when asked how they knew each slice of ham is 2-ounces and whether they weigh the ham, she said, 'no, they just estimate it'. When asked f they have a scale, she said, 'no, they still do not have a scale in the kitchen to weigh food'. When asked how long they have not had a scale, she said she noticed that when she arrived in May 2024. When asked if she had communicated a need for and lack of a scale to anyone, she said to her boss, Staff N, owner.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41837 Based on observations and interview, the facility failed to ensure food was stored and served in sanitary manner with potential to affect 53 of 55 residents. The findings included: During the initial kitchen tour conducted on 12/16/24 at 9:10 AM with the Certified Dietary Manager (CDM), the following was observed: a. Small refrigerator with open cheese in zip lock type plastic bag was not closed. b. Baking potatoes in a cardboard box under prep counter across from 2 compartment sink was wet and upon closer observation the potatoes in the bottom of the box were wet. c. Divided plates were stored right side up on shelf under prep table. Photographic Evidence Obtained. d. Two (2) red buckets with water and rag in each bucket. e. Unlabeled white granular substance in clear container with lid in beverage serving area. Photographic Evidence Obtained. f. Bottom shelf of beverage serving area covered with tin foil, pulled back to reveal rusty surface. g. Ice machine with missing panels on both sides, exposing corroded material and rust. h. Ice scoop in blue plastic holder on wall with large hole in bottom of the plastic container. i. Push cart with containers for hot beverages and condiments with rust on the cart near the wheels. j. In the walk in refrigerator were several open items with no date including jar of jelly, large container of mustard, large container of picante sauce, large container of pickles, 2 large containers of salad dressing, large container of soy sauce, large container of Worcestershire sauce. Also was an open container of sour cream with an expiration date of 12/02/24. k. The walk in refrigerator floor had cracks and was rusty around the parameter edges at base of walls. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	l. In the walk in freezer (0 degrees Fahrenheit) were several items opened and exposed to the air with no date including the following: half box of sausage patties, half box of sausage links, half box of pizza shells, box of green beans and box of kernel corn with freezer burn, box of pancakes and box of French toast soft to touch, boxes of turkey breast partially defrosted. There was condensation dripping from the ceiling onto the closed boxes of food. m. In the dry goods pantry, there were several open items with no date including the following, bag of macaroni, bag of yellow cake mix, bag flour inside a black plastic bag open, bag of mashed potatoes, clear plastic bin of oatmeal covered with ill-fitting broken plastic lid, second clear plastic bin with oatmeal covered with baking sheet, 3 bags of gelatin, 7 bags of bread, open container of dry mustard powder with no lid, 14 spices with no date, gravy mix. n. In the Caper Room (not marked as such), there were several supplies of paper and plastic items including napkins not sealed or covered with an umbrella next to the napkins. o. Restroom in kitchen with slicer covered with plastic bag and on a push cart. p. Thirty-six (36) florescent light fixtures in the kitchen over food preparation area, food cooking areas and dishwashing areas with cracks in the plastic covers and missing pieces of plastic. q. Two (2) white cutting boards with stains and several baking sheets and pots with dark matter stuck on inside surface that would come in contact with food. During an observation conducted on 12/20/24 at 1:45 PM in the kitchen, Staff M, Dietary Aide, was working on the tray line with no beard net over his beard, just a procedure mask under his chin. An interview was conducted on 12/16/24 at 9:10 AM with the Certified Dietary Manager (CDM) who stated she has worked at the facility since 05/28/24. She stated the maintenance personnel informed her the ice machine works better without the side panels. She was asked about the ovens and stated they (Administration) are aware of the ovens being broken and they are in process of getting them repaired. When asked about checking the red buckets for strength of sanitization, she said they contain no sanitation chemicals, just soap and water. When asked how they sanitize the food prep surfaces, she said they do not sanitize the food prep surfaces, they just clean them with soap and water. She added, they (Administration) knows about this.

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	105835	A. Building B. Wing	12/20/2024

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 39026 Based on observation, interviews and record review, the Administrator failed to ensure the facility was administered in a manner that enabled use of its resources effectively and efficiently which affected all 55 residents in the facility at the time of the survey. The findings included: 1. An interview was conducted with the Administrator / Risk Manager on 12/20/24 at 12:30 PM. The Administrator was apprised of the concerns of the survey team relating to Administration, as follows: a) Four Licensed Practical Nurses administering (IV) intravenous medications without IV certification. Refer to F694 for details. b) Discussed the resident who had an unwitnessed fall with fracture and who was not able to verbalize how it happened. There was no immediate or 5 day report done and the fall investigation did not determine how the fall occurred or what interventions were in/or not in place at the time of the fall. Refer to F689 for details. c) The Administrator was not aware the facility had a pest control issue and had not had a pest technician visit since 12/02/24 when the facility's exterior was treated. The next treatment was supposed to be interior but it had not been done yet. Refert o F925 for details. 41837 2. During the initial kitchen tour conducted on 12/16/24 at 9:10 AM with Staff Certified Dietary Manager (CDM) the following was observed: There were 2 broken ovens with signs labeled broken. Refer to F908 for details.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 39026 Based on observations, interview and record review, the facility's Quality Assurance and Performance Improvement Activities (QAPI/QAA) failed to demonstrate effective plan of actions were implemented to correct identified quality deficiencies in the problem area as evidenced by repeated deficient practices for F803, Menus Meet Resident Nds/Prep in Adv/Followed; F812, Food Procurement, Store/Prepare/Serve Sanitary; and F925, Maintains Effective Pest Control Program. These repeated deficient practices have the potential to affect all 55 residents residing in the facility at the time of this survey. The findings included: Review of the facility's survey history revealed the facility was cited F803 - Food and Nutrition Services related to menus, F812 - Food and Nutrition Services related to kitchen sanitation issues, and F925 - Physical Environment related pest control, during the Recertification and Relicensure survey with an exit date of 09/28/23. Review of the QAPI program with the Administraor revealed the lack of an effective corrective action plan for the above defeciencies. During an interview with the facility's Administrator on 12/20/24 at 12:30 PM, the Administrator was apprised that these 3 deficiencies would be cited on this current survey. This was acknowledged by the Administrator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on record review, observations and interviews, the facility failed to ensure they had implemented an infection control program that ensured a resident with a Peripherally Inserted Central Catheter (PICC) line was placed on Enhanced Barrier Precautions (EBP) for 1 of 8 sampled residents reviewed for EBP, Resident #365; failed to don proper Personal Protective Equipment (PPE) during perineal care observation for 1 of 1 sampled resident reviewed for indwelling catheter, Resident #19; and failed to ensure meal trays were transported in a sanitary manner for 1 of 3 meal tray carts reviewed during dining observations. The findings included: Review of the Centers for Disease Control and Prevention (CDC) guidelines, titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 07/12/22, documented, in part, at https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html, the following: Key Points: 2. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during contact resident care activities. 3. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling devices, regardless of MDRO colonization status. 4.Effective implementation of EBP requires staff training on the proper use of PPE and the availability of PPE and hand hygiene supplies at the point of care. Review of the facility's policy, titled, Infection Control, not dated, included the following: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission and infections. 1. Record review revealed Resident #365 was admitted to the facility on [DATE] with diagnoses that included: Fracture of neck, Pneumonitis and Dysphagia. He was admitted with a Peripherally Inserted Central Catheter (PICC) line. Review of Resident #365's physician orders revealed no order to place the resident on EBP. An observation was conducted on 12/18/24 at 10:07 AM of Resident #365's room which revealed no enhanced barrier precaution (EBP) sign on or near the door and no personal protective equipment (PPE) by or near the door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review revealed Resident #19 was originally admitted to the facility on [DATE] with the most recent readmission to the facility on [DATE] with diagnoses that included: Dementia, Dysphagia and Pressure Ulcer of Sacral Region, Stage 3. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 00, indicating she was rarely understood. Review of Section H revealed Resident #42 did not have an indwelling catheter. Review of Section M revealed Resident #42 had two Stage 3 pressure ulcers. Review of Section H of the MDS dated [DATE] Quarterly (in progress) revealed Resident #42 has an indwelling catheter. Review of the Physician's Orders showed that Resident #19 had an order dated 08/30/24 for Urinary Catheter Care every shift for Infection Prevention and as needed for Infection prevention; enhanced barrier precautions every shift. A perineal and catheter care observation was conducted on 12/18/24 at 10:44 AM for Resident #19 with Staff G, Certified Nursing Assistant (CNA), who was assisted by Staff H, CNA. Both CNAs took turns to wash their hands and applied clean gloves. Neither CNA applied a PPE gown. Staff G gathered the supplies, was assisted by Staff H to position Resident #19 to a comfortable position, and started to provide perineal and catheter care. Throughout the procedure, Staff G and Staff H would properly follow hand hygiene and applied clean gloves, however, no PPE gown was donned by either staff. An interview was conducted on 12/18/24 at 11:40 AM, Staff H, CNA, who stated she has worked at the facility for 7 years. She was asked about EBP. Staff H looked confused about the question and asked to repeat the question. Staff H was quiet for a moment and Staff G joined the interview. Staff G stated she has been working at the facility for [AGE] years and was asked about EBP. Staff G also looked confused and was unsure what EBP was, and then pointed at the PPE container sitting outside Resident #19's room and stated, is that what EBP is?. At this time, Staff G realized that neither Staff H or herself had applied a gown prior to providing perineal and catheter care to Resident #19. Staff H also realized that a gown was required for catheter care. An interview was conducted on 12/20/24 at 9:17 AM with the Director of Nursing (DON) who stated that Staff G had spoken with her and could not believe she forgot to apply a gown during catheter care. The DON acknowledged that donning on the proper PPE for catheter care should be automatic and part of the daily routine to provide care for residents on EBP. She also stated she realized Resident #365 should have had a physician's order for EBP, EBP signage, and a PPE cart outside of his door. 41837 3. On 12/16/24 at 8:50 AM, an observation was made of Staff I, Dietary Aide, pushing a metal meal cart tray with doors missing and dirty trays from breakfast and several plastic plate covers on top of the cart from the nursing station toward the kitchen. Photographic Evidence Obtained. On 12/17/24 at 9:00 AM, an observation was made of Staff J, Dietary Aide, pushing a metal meal cart tray with doors missing and dirty trays from breakfast and several plastic plate covers on top of the cart from the nursing station toward the kitchen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 12/16/24 at 8:52 AM with Staff I who stated he has worked at the facility for about 1 year. When asked how long the metal meal cart tray has been missing the doors, he said about a month. An interview was conducted on 12/16/24 at 9:20 AM with the Certified Dietary Manager (CDM) who stated she has worked at the facility since 05/28/24. When asked about the metal meal cart with missing doors being utilized, she said the cart has had no doors since May when she started, but they (Administration) are fully aware of this. An interview was conducted on 12/17/24 at 9:00 AM with Staff J who stated she has worked at the facility for about 1 year. When asked how long the metal meal cart tray has been missing doors, she said about 1 month.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 41837 Based on observations and interview, the facility failed to ensure kitchen equipment was maintained in safe operating conditions for 2 of 2 ovens, 1 of 1 freezer and 1 of 1 walk-in refrigerator. The findings included: During the kitchen tour conducted on 12/16/24 at 9:10 AM, an observation was made of 2 broken ovens, labeled with signs saying 'broken'. An interview was conducted on 12/17/24 at 1:20 PM with the Administrator and the Certified Dietary Manager (CDM) who stated there are 2 ovens in the kitchen and both are broken. When the CDM was asked if there is any equipment in the kitchen including the refrigerator and freezer, that has issues, the CDM stated that she felt there might be some issues with the walk-in freezer and the walk-in refrigerator since the initial tour of the kitchen with surveyor on 12/16/24. The administrator stated she had only discovered today that the walk-in freezer and walk-in refrigerator was not keeping food at appropriate temperatures and had contacted a vendor to come on 12/17/24 to repair the freezer, but they were unable to repair walk-in refrigerator. An interview was conducted on 12/20/24 at 1:50 PM with the CDM who was asked if they have a scale or weighing foods. She said, 'no they still do not have a scale in the kitchen to weigh food.' When asked how long they have not had the scale, she said she noticed that when she arrived in May 2024. When asked if she had communicated a need for and lack of a scale to anyone, she said to her boss Staff N, owner. An interview was conducted on 12/19/24 at 11:00 AM with the Administrator, who said she was unaware of kitchen not having a scale or of any issue with the refrigerator or freezer until this survey. The Administrator stated she received emails from Regional Director Of Maintenance (RDOM) and Chief Executive Officer (CEO) about the oven but was never provided any documentation from the vendor of invoices that the oven was ordered or the expected delivery.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51137 Based on observation, interview, and review of exterminator service inspection reports, the facility failed to maintain an effective pest control program, as evidenced by observed insects in all stages of life in 1 of 4 hallways ([NAME]), documentation of inconsistent extermination during the past five months, and voiced resident confirmation during interviews. The findings included: During a resident observation on 12/16/24 at 10:36 AM, roach activity was seen in Resident #7's room. Multiple dead roaches and a roach egg were noted behind the resident's bed. Upon further observation, 2 live roaches were seen crawling underneath the resident's bed and wheelchair. Photographic Evidence Obtained. During an interview on 12/16/24 at 11:07 AM, when asked if she had seen any insects in her room, Resident #22 voiced she had seen roaches in her room. She stated, I don't like them. During an interview on 12/16/24 at 11:14 AM, when asked if they had ever seen any bugs in their room, Resident #49 stated he had seen roaches on his side of the room but not as many as his roommate who was by the window. During an interview on 12/16/24 at 11:29AM, Resident #44, who is Resident #49's roommate, stated he has seen roaches everywhere, especially by his window. He voiced that he tried to kill them himself because there were so many. When asked if staff are aware of this issue, he stated that they were aware and they told the resident the pest control company was taking care of the matter but stated he still saw them afterwards. Resident #44 voiced, My family doesn't want to come and visit me because they are afraid to take the roaches home with them. During an interview on 12/16/24 at 02:19 PM, Resident's #43's representative stated she had seen roaches when providing care to the resident. During a follow-up observation on 12/17/24 at 9:10 AM, Resident #7's room still had dead roaches and a roach egg on the floor located behind the resident's bed. During a medication administration observation on 12/19/24 at 8:58 AM, a live roach was observed crawling out from underneath a resident's bed. During an interview on 12/19/24 at 1:09 PM, when asked if the facility had a pest control issue, the Nursing Home Administrator (NHA) stated that there was nothing she was aware of. The NHA was informed of the live crawling insects observed and the voiced confirmations made by multiple resident's and family members. The NHA was asked to locate and provide evidence of pest service for the past couple of months. Review of the service inspection reports by the exterminator revealed the following: On 08/01/24 and 09/01/24, a monthly service was provided by [Company Name} Exterminations where the exterminator was targeting rodents, flies and fire ants. (continued on next page)

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	105835	A. Building B. Wing	12/20/2024

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In October of 2024, no exterminator service was provided to the facility On 11/25/24, a biweekly service by [another Company Name] Solutions documented, While doing the initial inspection I was able to walk through and treat the entire facility. Critical areas such as the kitchen was baited and treated in the cracks and crevices. The soiled rooms, common areas, break rooms, and dining rooms. I only treated near the window and bathrooms in the patient's rooms. No obvious signs of insect activity was found today. On 12/02/24, a biweekly service by [Company Name] Solutions documented, The entire exterior of the building was treated for ants and other general household pests. There was lots of ant mounds all over the lawn and exterior of the building. I will continue to follow up on the treatment. Next treatment will be interior. When asked why the service changed from [Name provided] Exterminations to [Name provided] Solutions, the NHA stated that the company was too expensive and they needed a cheaper rate. The month of October with no pest control service to the facility was used to find the cheaper pest control company. When asked to provide evidence of the most recent service for the week of 12/16/24, the NHA stated the exterminator had an emergency and was not able to come out to the facility and is scheduled to service them next week. When asked if she thought the cheaper pest control company was effective she stated, No, not if there are still roaches in the facility.