STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106060	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Palm Bay	175 Villa Nueva Ave Palm Bay, FL 32907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on interview, and record review, the facility failed to ensure 2 of 3 residents reviewed for Care Planning were offered participation in plans or revisions to their care, out of a total sample of 54 residents, (#39, #86). Findings: 1. Review of the medical record revealed resident #39, an [AGE] year old male was admitted to the facility from an acute care hospital on 4/02/23. The resident's diagnoses included, abnormalities of gait and mobility, insomnia, major depressive disorder, anxiety disorder, osteoarthritis, Chronic Obstructive Pulmonary Disease (COPD), presence of cardiac pacemaker, acute kidney failure, atrial fibrillation (abnormal heart rhythm), artificial opening of urinary tract, and type 2 diabetes mellitus. The Minimum Data Set (MDS) Quarterly Assessment with an Assessment Reference Date (ARD) of 12/31/24 revealed during the look-back periods, resident #39 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) that indicated he was cognitively intact. The assessment showed there were no delusions or behaviors, the resident did not walk, required a wheelchair for mobility, staff supervision and assistance to complete activities of daily living (ADLs), he had frequent, very severe/horrible pain, received high-risk insulin, anti-coagulant (blood thinner), hypoglycemic (sugar lowering), and anticonvulsant (seizure) medications, and no active discharge plan to the community occurred. On 1/06/25 at 3:38 PM, resident #39 was observed sitting in a wheelchair in the facility's activity room. The resident explained he was not aware of his plan of care meetings, nor had he been invited to attend. He said he had problems with his meals, shoulder pain, and he hadn't received therapy that could help with his strength and movement in a long time. The resident stated, I need updates; I have a lot going on. Review of resident #39's Comprehensive Care Plan included focuses, interventions, and goals for Activities, Advanced Directives, ADL assistance and therapy services, ADL self-care performance deficit, insomnia, discharge planning, hearing deficit, risk for oral/dental health problems, diabetes mellitus, risk for falls, anticoagulant therapy, compression fracture, medication self-administration, potential nutritional problems, knee pain, risk for skin integrity breaks, suprapubic catheter care, bladder obstruction, impaired visual function, and COPD. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Order Summary Report included active physician's orders for Biofreeze Gel for pain, Melatonin 3 milligrams (MG) at bedtime for insomnia, Eliquis (blood thinner) 5 MG twice daily for blood clots, Gabapentin 100 MG three times daily for neuropathy, Brinzolamide 1% Suspension eye drops twice daily for glaucoma, Metoprolol 12.5 MG twice daily for blood pressure, Lantus Insulin 12 units at bedtime, Novolog insulin 5 units before meals, and Novolog Insulin as needed per sliding scale before meals for diabetes mellitus. The most recent Care Plan Conference Record dated 10/22/24 noted the resident's family representative was unable to be reached by phone. The form did not indicate the resident or his family were invited. On 1/09/25 at 9:06 AM, the Director of Rehabilitation checked resident #39's medical record and said the last time he received any Physical Therapy (PT) was in January 2024, one year prior. She said a screening for a resumption of services was available to the resident, if requested. She could not recall, and did not locate a recent screen for determination of services in the resident's medical record. On 1/09/24 at 9:24 AM, the Licensed Practical Nurse (LPN) MDS Coordinator explained long term care resident care plan meetings were scheduled every quarter and a business card with the date and time were provided to the resident. She acknowledged she could not locate any documented record of resident #39's most recent invitation. She stated, it's important for the resident [to attend the meetings] so they know if they've made progress, and if they have therapy, to discuss discharge planning and what to expect next if discharge is not pending. 2. Review of the medical record revealed resident #86, a [AGE] year old female was admitted to the facility from an acute care hospital on 12/28/23. The resident's diagnoses included, left hip fracture, muscle weakness, abnormalities of gait (walking pattern) and mobility, dementia, dysphagia (difficulty swallowing), heart failure, malnutrition, insomnia, arthritis, and history of falling. The most recent MDS Quarterly Assessment with an ARD of 12/19/24 noted resident #86 scored 7 out of 15 on the BIMS that indicated she was cognitively impaired. The assessment showed there were no delusions or behaviors, the resident did not walk, she required a wheelchair for mobility, and staff assistance to complete ADLs and mobility functions. The assessment indicated she had frequent, very severe/horrible pain, shortness of breath with exertion and when lying flat, received high-risk diuretic (fluid removing), opioid (narcotic pain) and anticonvulsant (seizure) medications, and that no active discharge plan to the community occurred. The Order Summary Report included active physician's orders for ace wraps to both legs for edema, Amlodipine 10 MG once daily for blood pressure, Diclofenac 1% gel to the left knee for pain, Dicyclomine 10 MG four times daily for irritable bowel syndrome, Enalapril 10 MG once daily for blood pressure, Gabapentin 400 MG three times daily for neuropathy, Lasix 40 MG once daily for edema, Levothyroxine 150 Micrograms (MCG) once daily for thyroid hormone, Percocet 5-325 MG twice daily and every 8 hours as needed for pain, Primidone 100 MG at bedtime for tremors, and Spironolactone 12.5 MG once daily for edema. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #86's Comprehensive Care Plan included focuses, interventions, and goals for Activities, Advanced Directives, Medication allergies, Activities of Daily Living (ADL) assistance and therapy services, ADL self-care performance deficit, insomnia, a return home discharge plan, impaired cognition, congestive heart failure, hearing deficit, potential for dehydration, edentulous (no natural teeth), hypothyroidism, risk for falls/history of falls, incontinence, irritable bowel syndrome with diarrhea, anemia, Rheumatoid Arthritis, left hip fracture, tremors, pain, risk for impaired skin integrity, potential nutritional problems, and impaired visual function for dry eyes. On 1/07/25 at 9:38 AM, resident #86 was observed sitting in a chair in her room. The resident said she was not aware there were care plan meetings or participated in plans and reviews of her care. Review of the most recent Care Plan Conference Record dated 12/31/24 did not note staff attempted to reach the resident's family and read, IDT meeting, Care Plan: Diet, Diagnosis, weight, code status discussed. No family present. On 1/09/25 at 9:16 AM, the Registered Nurse (RN) MDS Coordinator said family representatives were notified of care plan meetings by phone and the Care Plan Conference Records were marked by a check box when invitations were provided. The RN explained, it's [the meeting] important so they can speak on behalf of themselves; if they need to express something that's important to them; it's about them, they are the one who is here getting care; it's important for them to participate. On 1/09/24 at 2:45 PM, the DON explained the MDS staff reported to her and resident care plans were reviewed every morning with the Interdisciplinary Team. She said it was important for residents to have the opportunity to participate in their plan of care so they could voice their concerns and staff could look into any problems. Review of the facility's standards and guidelines titled, Comprehensive Care Plans and Revisions dated 9/11/24 read, .the facility will ensure . each resident and resident representative, if applicable is involved in developing the care plan and making decisions about his or her care. Review of the facility's Admission Packet included the residents' [NAME] Of Rights that read, . the resident has the right to be informed of, and participate in, his or her treatment, including the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical conditions, the right to participate in the development and implementation of his or her person-centered plan of care. the right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview, and record review, the facility failed to provide care and services in accordance with professional standards of practice related to not scheduling physician ordered specialist consultation, for 1 of 1 residents reviewed for , of a total sample of 54 residents, (#14). Findings: Resident #14 was initially admitted to the facility on [DATE] from an acute care hospital with diagnoses that included obstructive sleep apnea, atherosclerotic heart disease of native coronary artery, and presence of cardiac pacemaker. Review of resident #14's Annual Minimum Data Set assessment dated [DATE], revealed that she had a Brief Interview for Mental Status score of 14 out of 15 which indicated intact cognition. She had no upper or lower limb impairment and required minimal to no assistance with Activities of Daily Living. On 01/07/25 at 11:22 AM Resident #14 stated that she had been in the facility for over a year but had not seen the cardiologist to check the batteries of her pacemaker. She said that prior to being admitted to the facility she was seeing the cardiologist every six months and would like to see one. She reported that her son was involved and helped manage her care. According to the American Heart Association, pacemakers were indicated for people with abnormal heart rhythms, also known as arrythmias. Pacemakers should be checked every six months to a year to assess the battery and find out how the wires were working, (retrieved from www.heart.org/en/health-topics/arrhythmia/prevention on 1/10/25 at 3:00 PM). Review of resident #14's active physician orders revealed that on 10/15/24 there was a prescriber written order for a cardiology consult to check the pacemaker. There was no documentation in the medical record to show that the facility had scheduled the appointment or that the resident had scheduled it on her own. Review of resident #14's medical record revealed a care plan for pacemaker care initiated on 11/27/23 with interventions that included cardiology consult as ordered, pacemaker checks as ordered, and documentation in the medical record of heart rate, rhythm, and battery check. Both interventions were initiated on 10/16/24 but there was no documentation in the medical record indicating that a battery check had been done per the plan of care. Review of the Care Plan Conference Record for resident #14 dated 12/03/24, revealed the resident's son attended the meeting and asked about scheduling a cardiologist appointment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/09/25 at 10:14 AM, the Unit Manager (UM) of the Bayside unit confirmed she was responsible for scheduling appointments. She said that every morning she would print out the orders for all residents on the unit to verify if any consults had been ordered. She confirmed that resident #14 was ordered a cardiology consult on 10/16/24 but she was unable to find any documentation that showed the consult had been scheduled. She said that she had been hired on 10/31/24 and was unsure why the order had not been followed. She said that she must have missed it when she printed out the orders every morning. The Director of Nursing was also present during the interview with Bayside unit UM and stated that her expectation was for physician orders to be followed by staff or have documentation to reflect why an order was not followed and the physician notified. Review of the facility's Policies and Procedures on Physician Orders revised 2/26/24, revealed that the facility was obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines.