STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106091	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luxe at Wellington Rehabilitation Center The	10330 Nuvista Avenue Wellington, FL 33414

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews, and record review, the facility failed to thoroughly investigate a fall with major injury for 2 out of 3 sampled residents reviewed for Falls (Resident #2 and Resident #6). The findings included: 1) Record review for Resident #2 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Displaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter For Closed Fracture With Routine Healing; History Of Falling; Acute Respiratory Failure with Hypoxia; Acute Posthemorrhagic Anemia; Unspecified Glaucoma; Chronic Obstructive Pulmonary Disease; Need For Assistance with Personal Care; Difficulty In Walking; and Bacteriuria, dated 03/06/24 (During Stay at Facility). Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #2 had a Brief Interview for Mental Status of 09, which indicated that she was moderately cognitively impaired. Review of Section GG revealed that Resident #2 required partial/moderate assistance for toileting, shower, upper body dressing and transfer chair/bed-to-chair. Section I revealed that Resident #2 did not have a Urinary Tract Infection (UTI) in the last 30 days. Review of the Physician's Orders showed that Resident #2 had orders dated 01/08/24 which included: Acetaminophen Tablet 325 MG, Give 2 tablet by mouth every 6 hours as needed for pain Do not exceed 3 gm in 24 hour period; Latanoprost Solution 0.005 %, Instill 1 drop in both eyes at bedtime for glaucoma; Sertraline HCl Tablet 50 MG, Give 1 tablet by mouth one time a day for Depression; Mirtazapine Tablet 15 MG, Give 1 tablet by mouth at bedtime for depression associated with weight loss; Hydrochlorothiazide Oral Tablet 12.5 MG , Give 1 tablet by mouth one time a day for edema; Skilled Physical Therapy (PT) 5x/week x 90 days with tx modalities may include Therapeutic Exercises, Therapeutic Activities, Gait training, and Group Therapy. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Luxe at Wellington Rehabilitation Center The		STREET ADDRESS, CITY, STATE, ZIP CODE 10330 Nuvista Avenue Wellington, FL 33414	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan dated 01/09/24 documented that Resident #2 needed assistance with Activities of Daily Living (ADL) care related to multiple factors including weakness/decreased mobility s/p (status post) recent hospitalization /illness. Goals: Resident will maintain and/or improve current level of function. Interventions were to observe resident for changes in ADL capabilities. Notify nurse, therapy, and/or MD as indicated. Assistive devices as ordered/indicated. The care plan also revealed that Resident #2 was at risk for falls R/T (related to) Cognitive Deficit, History of Falls, Impaired vision, Unaware of safety needs, Use of antihypertensive medications, Use of psychotropic medications. Goals: resident's potential for sustaining a fall-related injury will be minimized by utilizing fall precautions/interventions. Interventions was to assist resident to use bed in the lowest position as tolerated; Remind resident to use call bell and to wait for staff assistance with transfers, ambulation, toileting, etc. as indicated. Review of the Progress Note/assessment dated [DATE] documented Resident #2 was observed on the floor next to her bed laying on the right side when she was asked what happened resident stated, I do not remember how I ended up on the floor. Resident complaint of right hip pain upon movement. The Advanced Nurse Practitioner (ARNP) was made aware, and X-ray was ordered. Review of Resident #2's progress notes dated 03/08/24 documented the facility received orders to send the resident to the hospital for a hip fracture. [Family] made aware and an ambulance was called. The resident was transferred to the hospital for treatment. Review of the facility's investigation report dated 03/10/24 regarding Resident #2's fall revealed that there were two nurses interviewed and no documentation nor statements from other nursing staff that were scheduled to care for Resident #2 on 03/08/24. In conclusion, no evidence of a thorough investigation was noted for Resident #2's fall with a major injury. During an interview conducted on 05/02/24 at 12:37 PM, with the facility's Administrator. He stated that the Fall/Neglect investigation for Resident #2 was conducted according to the facility's protocol. He stated that the concentration of the investigation was to identify whether Resident #2's daughter was contacted after the Fall in a timely manner, not how the Fall happened. He also stated that Resident #2 was able to communicate how she was observed on the floor and the nursing staff followed the resident's care plan. He was then asked how does he know if the Care plan was followed prior to the Fall. The Administrator reviewed the investigation report, and he agreed that Resident #2's fall investigation was not properly conducted and had no documentation to prove that the care plan was followed. 2) Record review for Resident #6 revealed that the resident was admitted to the facility on [DATE] with the following diagnoses: Pleural effusion; Encounter for surgical aftercare following surgery on the respiratory system. Readmitted d 04/27/24 with the following diagnosis: Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing; and Presence of Right artificial hip joint. Review of Section C of the Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #6 had a Brief Interview for Mental Status of 14, which indicated that she was cognitively intact. Review of Section GG revealed that Resident #6 required partial/moderate assistance for toileting and showering; Supervision/touching assistance for toilet transfer and walking 150 feet once standing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Luxe at Wellington Rehabilitation Center The		STREET ADDRESS, CITY, STATE, ZIP CODE 10330 Nuvista Avenue Wellington, FL 33414	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders showed that Resident #6 had an order dated 03/27/24 for Acetaminophen Tablet 325 MG, give 2 tablets by mouth every 6 hours as needed for pain, Do not exceed 3 gm in 24 hour period. Enoxaparin Sodium Solution 30 MG/0.3 ML, inject 30 mg subcutaneously one time a day to prevent blood clotting s/p Hip Surgery dated 04/27/24. Methimazole Oral tablet, give 2.5 mg by mouth in the morning for Hyperthyroidism, TSH slightly low dated 04/29/24. Torsemide Oral tablet 10 MG, give 1 tablet by mouth onetime a day for Congestive Heart Failure (CHF) dated 03/27/24. Review of the Care Plan dated 03/13/24 documented that Resident #6 was at risk for falls r/t (related to) decline in functional status, generalized weakness, gait dysfunction, and impaired vision; Resident #6 was on a Diuretic Therapy related to diagnosis of Congestive Heart Failure; in addition, Resident #6 needs assist with ADL care related to multiple factors including weakness/decreased mobility s/p recent hospitalization s/illness; At risk for complications r/t bowel and/or bladder incontinence. Goals and Interventions were in place. Review of the Progress Note/assessment dated [DATE] documented Resident #6 was witnessed on the floor in a sitting position. She was assessed and a skin tear was noted to the right elbow and right leg. Resident #6 denied hitting her head, pain medication Tylenol was given. MD (Medical Doctor) and family were notified. Review of the Progress Note/assessment dated [DATE] documented Resident #6 was seen by her Physician, X-ray results were received and Resident #6 was transferred to the hospital with diagnosis of Right hip fracture. Review of the In-service Education titled, When there is a fall with or without injury, conducted on 04/10/24 for all nurses/all Certified Nursing Assistants (CNAs) on all shifts revealed the following instructions: 4-Statement by the nurse and CNA caring for resident. If you were on a break your statement MUST describe when the last time you saw the resident, what he/she was doing and who informed you of the incident. 5-If someone from another department observed the resident on the floor or assisted you to get the resident off the floor that employee MUST write a statement. 6-What did the room look like? Was the floor wet or dry? Were there nonslip socks on? Was the room dark? During an interview conducted on 04/30/24 at 12:15 PM with Resident #6. She stated that she was trying to transfer from the bed to the chair and missed the handle of the wheelchair. She explained that she didn't know how it happened because it happened so quickly. She fractured the right hip and had a skin tear on the right leg. She stated that she was doing so well with her Physical Therapy (PT), now she was in pain and was starting PT again. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Luxe at Wellington Rehabilitation Center The		STREET ADDRESS, CITY, STATE, ZIP CODE 10330 Nuvista Avenue Wellington, FL 33414	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 05/02/24 at 12:37 PM, with the facility's Administrator. He stated that an incident report was filled out by Resident #6's nurse on 04/21/24. Review of the incident report revealed that no statements were collected from the nursing staff caring for Resident #6 on the day of the incident nor an investigation was conducted. The lack of investigation into a Fall with Major Injury was discussed with the Administrator. In addition, he stated that an investigation should have been done since Resident #6 was on diuretic medication and other medications that placed the resident at risk for Falls.