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	10/30/2024

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 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** 29151 Based on clinical record review and interview, the facility staff failed to provide necessary care and services to ensure adequate monitoring for 2 of 3 sampled residents (Resident #1 and #2) who experienced significant changes in condition requiring hospitalization ; and the facility failed to assess skin changes for 1 of 3 sampled residents (Resident #3) after skin impairments were identified and treated to ensure resolution. The findings included: 1) Clinical record review revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] after a short hospitalization due to Hematuria. Review of the Minimum Data Set, admission assessment with reference date of [DATE], documented the resident was assessed as independent for skills of daily decision making, has an indwelling urinary catheter and was receiving anticoagulant, antibiotic and hypoglycemia medications. The resident did not receive oxygen therapy. Review of Care Plans revised on [DATE], documented the following: The resident is at risk for potential fluid imbalance related to status post infection, sepsis and urinary tract infections. The interventions included: Lab/diagnostic work as ordered, notify MD (Medical Doctor) as indicated, monitor and document intake and output as per facility policy/MD order, monitor vital signs as ordered/per protocol and record. The resident has a risk for injury/infection related to presence of catheter secondary to chronic Foley catheter use, recurrent urinary tract infections and obstructive uropathy. The interventions included: Irrigate catheter as per MD order, monitor and document intake and output per MD orders and monitor for signs of bacteriuria: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Report abnormalities to nurse/MD as needed. Review of Progress Notes dated [DATE], documented patient in bed alert, no apparent distress noted. Tolerated medication well. Foley catheter in place with bright red blood noted, irrigation initiated. Practitioner aware and report given to upcoming nurse to continue monitor. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Practitioner Progress Notes dated [DATE], documented seen today in a bed. case discussed with nurse, hypotensive, weak, normal saline started, Foley flushed as hematuria worsening again, urinalysis and labs ordered, if continue with low blood pressure send out. Review of a document titled, SBAR Summary for Providers dated [DATE] documented, Situation: The Change In Condition reported Bleeding (other than GI). At the time of evaluation [DATE] at 11:20 AM resident's blood pressure ,d+[DATE], pulse 41 and pulse oximetry 91 percent via oxygen mask. Review of the Transfer to Hospital Summary dated [DATE] documented, Patient observe with labored breathing. Vital signs blood pressure ,d+[DATE], heart rate 100, oxygen saturation 85%. Patient placed on Non-Rebreather mask at 15 liters. Patient assessed at bedside by practitioner. Order receive for chest x-ray and intravenous fluids. Midline inserted, intravenous fluid in progress. Patient with profuse bleeding in diaper and at Foley catheter site. Vitals signs ,d+[DATE], heart rate 41, oxygen level 91% on non-rebreather mask and practitioner notified. Telephone orders received to transfer patient to hospital for further evaluation and treatment. 911 notified and patient left facility at approximately 11:45. Review of a Fire Rescue report dated [DATE] disclosed the emergency team arrived at the facility on [DATE] at 11:24 AM, Male patient found lying in bed unresponsive with blood-soaked sheets all over and a blood-soaked diaper. EMS (Emergency Medical System) rescue crew holding pressure to patient's penis stating that he was actively bleeding coming from the tip of his penis and they were unable to stop. Facility machine noted last blood pressure ,d+[DATE]. Staff was unable to provide accurate timeline of how long patient had been bleeding for, by the amount of blood in the bed it appeared patient had been bleeding for a while. EMS requested via phone a unit of blood, initially treating hemorrhagic shock, patient went into cardiac arrest and cardiopulmonary resuscitation started. Review of emergency room records dated [DATE] documented the medical screening exam at 12:01 PM, the patient presents in cardiac arrest. Per EMS they were called for excessive bleeding from the penis. Upon arrival he was hypotensive and had blood on the bed presumably from the penis. Patient was pulseless and apneic upon arrival . intubated, no evidence of trauma, ultrasound was placed on the heart, there was some mild quivering, but no cardiac output noted. No return to spontaneous circulation after multiple rounds of ACLS (Advance Cardiac Life Support) and defibrillation. Patient was pronounced not compatible with life at 12:50 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Staff A, Licensed Nurse, who cared for Resident #1 on [DATE], was conducted on [DATE] at 3:13 PM. Staff A recalled that she came in that morning and the resident was not feeling well, he was pale, his blood pressure was low, and she prioritize him. Staff A called the practitioner, she came in gave order for fluids and other tests, the IV (intravenous team) happened to be in the building and they inserted the line right away. So she started the fluids. Resident #1 had chronic hematuria, was previously sent to the hospital for a CBI (continuous bladder irrigation) and returned with the urinary catheter. Staff A was asked how the urinary output was and was the catheter draining, she replied the Foley was draining and after starting the fluids his blood pressure went up. Then, later on, the assigned aide went to clean him up and noticed the gross amount of blood, 'it was a lot, and called her to the room. Staff A then immediately called the provider and got orders to send him out and she called 911. Staff A stated that it was a good thing that the aide went to change him then, otherwise she would not have noticed the blood, he had the covers pulled up and there is no way she would have seen it. The nurse was asked what type of monitoring was conducted and stated she checked his blood pressure, and it was better, she thinks 103 or so, she can't recall the exact number and acknowledged there is no documentation of an assessment and monitoring after the change in condition and prior to the transfer to the emergency room . During interview with the Nurse Practitioner (APRN) conducted on [DATE] at approximately 10:30 AM revealed Resident #1 had chronic hematuria, he was sent to the hospital multiple times, and the urologist decided to only treat him with Flomax. The hematuria was improving. The date of the transfer, the resident's blood pressure was low, and the hematuria returned. The nurse called her, and she examined the resident and ordered fluids and blood work. The nurse told her the blood pressure was improving, then later on she received another call that the blood pressure and oxygenation had dropped, and he had significant bleeding, she sent him out to the emergency department. The APRN stated the resident had been cleared to continue his Pradaxa, anticoagulant medication, and that she ordered the fluids to manage the low blood pressure. Interview with Staff C, Certified Nursing Assistant, conducted on [DATE] at 1:54 PM revealed she was the aide assigned to care for Resident #1. That morning she came in and was passing breakfast and caring for her residents. Around mid-morning, she went to the resident, the resident next door wanted a shower and she decided to see Resident #1 first. When she entered the room, she asked him how are you?, and he could not respond, he was trying. She thought he was having a stroke, she then pulled the sheets off and saw all the blood all over the bed and starting yelling for the nurse emergency, emergency. The nurse came in and went out to get oxygen and supplies and told her to go ahead and give the shower to the resident next door and the nurse told her that she had it under control. She was not in the room when the medics arrived and was asked what type of report did she get from the night aide, or the nurse, and replied she did not get any, no one told her there was anything wrong with the resident. Interview with Staff G, the night shift nurse, conducted on [DATE] at 2:10 PM revealed the staff had no recollection of the resident, then after reading her notes, Staff G stated the resident had blood in the catheter and she called the practitioner and irrigated the catheter, but was unable to describe how much blood. Staff G stated she completed an assessment, the blood pressure was fine, his abdomen was not distended but was not sure if she documented the findings. Record review and interview revealed Resident #1 had a change in condition, identified by Staff G, the night nurse, who documented as bright blood in the resident's urinary catheter. The nurse reported the findings to the provider, irrigated the catheter and gave report to Staff A, the day nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff G did not document an assessment after the change in condition, there were no vital signs, blood pressure and pulse, there was no documentation as to the amount of blood or urine in the Foley catheter and there is no documentation of an assessment or finding after the irrigation. Staff A obtained vital signs, documenting low blood pressure ,d+[DATE] and heart rate of 100 on [DATE] at 8:25 AM and received orders from the practitioner. There was no evidence of a subsequent assessment monitoring the amount of blood in the urinary bag, patency of the catheter, abdominal distention, or any active bleeding, or vital signs. The next assessment was documented on [DATE] at 11:20 AM, the resident had profuse bleeding, blood pressure ,d+[DATE], heart rate 41 and oxygen level 85% on room air. There was no evidence the staff assessed and closely monitored the patient for signs of bleeding. 2) Clinical record review revealed Resident #2 was admitted to the facility on [DATE] for rehabilitation after a knee replacement. Minimum Data Set, admission assessment with reference date of [DATE] documents the resident was independent was skills of daily decision making, had occasional pain and received opioids and antiplatelet medications. Review of Resident #2's Care Plan titled, Resident is at risk for potential fluid imbalance related to the use/side effects of medication, status post Hyponatremia dated [DATE] documents the resident will remain free of signs of fluid overload through review date, as evidenced by decrease in or absence of edema, anxiety, agitation, restlessness, confusion, changes in mood or behavior, nausea/vomiting, dyspnea, congestion, orthopnea, easily fatigued, jugular vein distension. The interventions included: Lab/diagnostic work as ordered. Notify MD (Medical Doctor) as indicated and monitor vital signs as ordered/per protocol and record, notify MD of significant changes. Review of an IDT (Interdisciplinary Team) Note, dated [DATE] documented Patient referred to skilled speech by rehab services, reported decline with oral intake/cough with thin liquids. Daughter at bedside; patient lethargic and unable to follow commands, no verbalization/vocalization. Daughter requested transfer to hospital; APRN (Advance Practitioner Registered Nurse) following and collaborated with family following request. Daughter reported plan to initiate fluids. Per aide all solids/liquids deferred during the morning. Patient is not alert for oral intake. Did not follow one step command however utilized simple hand gestures with no verbalizations. Daughter aware regarding current status and not safe for oral intake. Nurses notes dated [DATE] documented Patient alert with confusion. New orders received. IV fluids started to prevent dehydration, chest x-ray and electrocardiogram done. EKG result sent to MD. Doppler of LE (lower extremity) ordered. Patient is sleeping most of the day, complained of abdominal discomfort. Pain medication given as scheduled, and effective. MD notified and report given to the night shift nurse to follow up. Review if Physician order dated on [DATE] at 11:03 AM documented STAT complete blood count, basic chemistry profile and urinalysis for confusion. A Physician's order dated [DATE] at 11:35 AM documented STAT ultrasound to bilateral left lower extremities rule out blood clots. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Physician/Practitioner Progress Notes dated [DATE], documented *Patient also seen by myself yesterday, confusion and groggy-arousable. similar symptoms with UTI (Urinary Tract Infection) last week and improved with intravenous fluids and antibiotic, appeared dry, little water intake per daughter at bedside, patient reports some abdominal discomfort with palpation, patient has been having bowel movements per staff. Recently treated for urinary tract infection with antibiotics and improvement in white count and was doing well after treatment, Daughter reported she was doing well after treatment and that these new symptoms started ,d+[DATE]. Ordered multiple imaging studies, restart antibiotic, stat labs, intravenous fluids discussed with RN yesterday. Not all of above studies resulted. Reviewed electrocardiogram with medical doctor as well last night, possible tachycardia from dehydration. This AM similar symptoms and recommended pt transfer to emergency room for more in-depth work up. Review of progress notes dated [DATE], documented Resident received in bed, alert and responsive to herself. Round 7:40 vital signs was stable blood pressure ,d+[DATE], pulse 95, oxygen saturation 97% room air. At 8:50 AM, recheck vital signs blood pressure ,d+[DATE], pulse 128, temperature 97.4, respiration 19. IV fluid given,nebulizer treatment and oxygen for comfort per ARNP. Resident transferred to hospital via 911. Her daughter was at the bed side. Resident #2's record provides no evidence of the results of the ultrasound and blood work ordered STAT on [DATE]. The record provides no evidence of nursing reassessments after Staff C identified a blood pressure reading of ,d+[DATE] documented at 8:40 AM and there are no subsequent monitoring prior to the transfer to the emergency room at 10:53 AM. Review of the Fire Rescue report documented that on [DATE] at 10:53 AM, Resident #2 was found lethargic, slow to respond. The [family member] states that the patient has been lethargic over the past several days and this morning her blood pressure was found to be lower than normal. Emergency Medical System, staff on the scene documented systolic blood pressure only can be obtained manually and below 80. During transfer patient was upgraded to sepsis alert. emergency room records revealed the medical screening exam dated [DATE] at 12:12 PM. The exam documented Resident #2 presents with complaint of altered mental status, per daughter this has been ongoing for the last couple of days. Emergency medical system was called to the scene due to patient being unresponsive and hypotensive. Laboratory studies revealed critical white blood cell count of 72 (normal range 3XXX,d+[DATE].8). Interview with the Physician Assistant on [DATE] at approximately 10:35 AM revealed Resident #2 started to exhibit changes the day before the transfer, she was previously treated for a urinary tract infection with Ceftriaxone and fluids and responded well. This time she had the same symptoms, so she ordered STAT labs, electrocardiogram, chest x-ray and ultrasound. The next day, the resident was still not feeling better, and Resident #2 was sent out to the hospital. The STAT orders are completed within four hours, she received the electrocardiogram result and reviewed it with the physician but did not get the rest of the labs or ultrasound results, she was not sure if it was done. Interview with Director of Nursing (DON) on [DATE] at 12:53 PM revealed the nursing staff is to complete a nursing assessment after changes in condition are identified. The DON reviewed Resident #1 and Resident #2 clinical records and confirmed there is no documentation of assessment and monitoring after the changes in condition were identified. The DON was asked for a policy on how the staff handles medical emergencies. It was not provided. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Staff C, the Registered Nurse, assigned to care for Resident #2, was conducted on [DATE] at 1:34 PM. Staff C recalled entering the resident's room and saw the resident attached to the blood pressure machine, she pushed the machine and the vital signs were okay. Then later the [family member] came to her and told her that the resident was declining, she pointed to the physician assistant that was in the hallway and stated that the [family member] should talk to the PA. Staff C stated she saw them both talking, but nothing was said to her. Staff C went back in the room and repeated the vital signs, the blood pressure was low, she started to go through the medications, to see what she could do to help her and noticed that she did not have intravenous fluids going, and gave her intravenous fluids that had been ordered, a nebulizer treatment and oxygen. Staff C was asked three times to confirm her notes, documenting the blood pressure reading of ,d+[DATE] was obtained at 8:50 AM and confirmed that was correct. The staff was asked how she continued to monitor the resident and stated she obtained another blood pressure, and it went up to the 100's and that she completed an assessment, but it was not documented. Furthermore, Staff C shared text messages between her and the PA (physician assistant) validating the nurse contacted her requesting a call back, then sent another text stating Resident #2 needs to go out 911 and the PA responded that she had told the unit manager that Resident #2 could go to the hospital via AMR (regular ambulance transport) but if unstable to call 911. Staff C stated she was not made aware of the recommendation. Interview with the DON and the Chief Nursing Officer conducted on [DATE] at approximately 4 PM revealed the STAT orders for Resident #2 were inputted under the prescriber tab instead of telephone or verbal. This means the staff has to go in the electronic system and move the order from one section to another for implementation. The DON showed the computer screen where the providers continue to enter the orders in this format and the staff must go in multiple times a day to correct them. There is no evidence the diagnostic tests, STAT ultrasound and STAT laboratory studies were completed. 3) Clinical record review revealed Resident #3 was admitted to the facility on [DATE] with diagnosis of Heart Failure. Upon admission Resident #3 was assessed with a Braden score 08, low risk of developing pressure ulcers. Review of the Minimum Data Set, admission assessment with reference date of [DATE], documented the resident had no pressure wounds on admission. Review of the Care Plan titled, Resident is at risk for skin impairment elated to decreased mobility, Diabetes and Malnutrition, dated [DATE] documented the resident will be free from any new skin impairment through the review date. The interventions included: Encourage and assist resident to minimize pressure to bony prominence's as tolerated, encourage and assist resident to turn and reposition as tolerated and skin checks weekly and as indicated, and report any signs of skin breakdown to physician and wound team as indicated. Physician orders and treatment administration records documented Resident #3 received Zinc Oxide ointment 10 percent for skin condition, redness to the buttocks from [DATE] thru [DATE]. The clinical record failed to provide evidence of a skin assessment of the skin condition, redness blanchable or non-blanchable and evidence that the area of concern had resolved after the seven-day treatment was completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Weekly skin check dated [DATE], documented the resident's skin was intact. Subsequent skin check dated [DATE] provided no documentation. Interview with the Chief Nursing Officer (CNO) on [DATE] at approximately 4 PM revealed there are no nurses' notes assessing the skin impairment and documentation that it had resolved. The CNO provided provider notes dated [DATE] thru [DATE], all the notes documented pressure ulcers as per RN notes and skin checks per RN, wound care per facility protocol, RN to notify primary of skin changes or decubitus ulcers. There were no description of the skin impairment. Record review and interview confirmed the clinical staff failed to complete pertinent nursing assessments and monitoring after changes in condition were identified involving Resident #1 and Resident #2. Resident #1 expired in the emergency room and Resident #2 was still hospitalized as of [DATE]. In addition, the clinical staff failed to ensure skin condition was properly assessed to determine if the skin impairment met criteria for pressure wound and failed to document resolution or worsening of the skin condition after the prescribed treatment was completed for Resident #3.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 29151 Based on observation, interview and record review, the facility failed to implement care practices to prevent excessive tension on the indwelling urinary catheter to minimize complications. The failure affected 1 of 1 sampled resident (Resident #6). The findings included: Review of CDC recommendations for catheter care include the following: Properly secure catheters to prevent movement and urethral traction, maintain a sterile closed drainage system, maintain good hygiene at the catheter urethral interface, maintain unobstructed urine flow and maintain drainage bag below level of bladder at all times. Observation of catheter and wound care for Resident #6 was conducted on 10/29/24 at 9:38 AM. Staff D, a Certified Nursing Assistant, the Wound Care Nurse and the Unit Manager assisted with the provision of care. Staff D and the Wound Care Nurse prepared their supplies, performed hand hygiene and donned proper personal protective equipment. Staff D started the provision of care with the Wound Care Nurse by opening the resident's brief and turning the resident to place a pad underneath. It was noted the resident's catheter was not anchored to prevent pulling, there was a blue clamp, and a securement device attached to the catheter tubing. The device was wrinkled up and not attached to the resident's skin and the blue clamp was not in use as well. When the staff turned the resident to right side to place a pad, the resident moaned, the staff asked what hurt and the resident responded her back. It was noted the catheter tubing was pulling as the catheter bag remained attached to the side of the bed. Staff D provided catheter care, and the Wound Care Nurse was observed removing the crumbled-up securement device from the urinary catheter tubing and discarded it. Then the Wound Care Nurse and the aide turned the resident to the left side, again the catheter tube was pulling as it was not secured. The Unit Manager then intervene by placing the catheter bag on top of the bed, at the same level as the bladder, and the wound nurse performed wound care. The Wound Care Nurse and the aide then repositioned the resident and placed the catheter bag back to the side of the bed, and did not secure the catheter with the blue clamp or obtain another securement device for the urinary catheter. Interview conducted on 10/29/24 at 10:05 AM with the Unit Manager confirmed the resident's urinary catheter was not secured during the provision of care and the urinary bag was placed on top of the bed to minimize pulling, the manager stated the Wound Care Nurse was going to replace the securement device. Review of the Minimum Data Set assessment with reference date of 10/22/24 documented Resident #6 was assessed as severely impaired for skills of daily decision making and has an indwelling urinary catheter. Review of the Care plan titled, resident has a risk for injury/infection related to the presence of catheter secondary to a diagnosis of obstructive uropathy, dated 10/17/24, documented interventions as check catheter tubing for patency as indicated/needed and monitor for signs of bacteria and position catheter bag and tubing so that it promotes dignity and drainage.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 29151 Based on policy review, record review and interview, it was determined, the facility failed to ensure licensed nurses were able to demonstrate competency related to the provision of medication administration and following physician's orders. This failure affected 2 of 3 sampled residents (Resident #2 and #3). The findings included: 1) Clinical record review revealed Resident #3 was admitted to the facility for rehabilitation services with multiple diagnoses including Heart Failure and Hypertension on 10/07/24. Review of Physician's orders dated 10/08/24, documented Amlodipine Besylate 5 milligrams give 1 tablet by mouth two times a day, scheduled at 9 AM and 9 PM and Carvedilol Tablet 6.25 milligrams, give 1 tablet by mouth every 12 hours for Hypertension, scheduled at 9 AM and 5 PM. The medications have prescribed parameters, hold for systolic blood pressure less than 110 or heart rate less than 60. Review of the Medication Administration Record dated 10/2024, documented Resident #3 received the prescribed medications identified above with no evidence of blood pressure monitoring on the following days: 10/09/24, 10/10/24, 10/11/24, 10/16/24, 10/17/24, 10/21/24 and 10/22/24. 2) Clinical record review revealed Resident #2 was admitted to the facility for rehabilitation services on 09/09/24 with multiple diagnoses including Heart Failure and Hypertension. Review of Physician's orders dated 09/16/24, documented Methocarbamol Oral Tablet 500 mg, give 1 tablet by mouth every 12 hours for spasms, and hold for systolic blood pressure less than 105 or heart rate less than 60, hold for lethargy/drowsy. Review of the Medication Administration Record dated 10/2024, documented Resident #2 received the prescribed medications on 10/04/24 at 9 PM with blood pressure reading of 100/61 and on 10/22/24 at 9 AM with blood pressure reading of 104/69. Interview with the Director of Nursing and the Chief Nursing Officer on 10/29/24 starting at approximately 4 PM confirmed the staff who put in the order for Resident #3, did not add the field to document the vital signs. The DON confirmed the staff administered the medication to Resident #2 despite the prescribed parameters.