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	04/16/2025

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 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** 39026 Based on observation and interviews, the facility failed to provide residents with a dignified existence and communication with staff in and outside of the facility for 3 of 4 sampled residents reviewed for resident rights (Resident #6, #7 and #8). The findings included: 1). In an observation conducted on 04/16/2025 at 2:00 PM on the second floor of the facility, the surveyor noted that the nurses' station was empty. The surveyor walked around for 45 minutes and never saw a staff member. There were 40 residents on this second floor unit. 2). In an interview conducted on 04/16/2025 at 2:35 PM Resident #6's wife stated that she can never get in contact with the facility staff when she calls, she always must come to the facility if she has a question which is never answered because it seems that no one ever has an answer. Resident # 6's wife further stated that she doesn't see nurses nor CNA's (certified nursing assistants) around during her visits. Record review revealed Resident #6 was admitted on [DATE] post CVA (cerebrovascular accident). His Brief Interview of Mental Status (BIMS) score was 11 on the 5-day Minjimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/01/25. This indicated mild cognitive impairment. 3). In an interview conducted on 04/16/2025 at 2:20 PM Resident # 7's wife stated that she would love to see staff members come into her husband's room to care for him because she comes in the morning and leaves in the afternoon and the only time that she sees a staff member is for med pass and at lunch. If they need anything, no one is around to help them. She further revealed that her husband has been waiting to see a speech therapist for days now. And that exactly today she got a call from her insurance company saying that the doctor came to see her husband, but she spent the whole day with the husband and didn't see any doctor come around. Resident # 7's wife also stated that it's pointless talking to the front desk because their answer is always: I will investigate and get back to you which never happens. Record review revealed Resident #7 was admitted on [DATE] post CVA. His BIMS score was 14 on the admission MDS with an ARD of 04/13/25. This indicated intact cognition for this resident. (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	4). In an interview conducted on 04/16/2025 at 2:30 PM, Resident #8 stated angrily that she spent the whole day trying to find social services from the facility phone with no success. Every time she calls the front desk she gets transferred to Social Services and no answer. Resident # 8 stated that this facility is very big and nice, but the staff members are not so nice. Record review revealed Resident #8 was admitted on [DATE] for aftercare following joint replacement surgery. Her BIMS score on the 5-day MDS with an ARD of 04/14/25 was 15. This indicated the resident had intact cognition. On 04/16/25 at 3:20 PM, the Administrator was apprised of the interviews with the residents and representatives and stated that she receives messages on her phone from residents, and families come into her office all of the time to speak with her. During further interview, it was discussed regarding Resident #8 not being able to reach the social worker today, she responded that the social worker is off today.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observations, interviews, record and policy review; the facility failed to protect a resident's right to be free from neglect by failure of staff to respond timely to the resident's change of condition which resulted in hospitalization for 1 of 2 residents sampled for change in condition (Resident #4). The findings included: The facility's policy titled Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin issued 08/2022 and revised 01/2024 revealed, Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident (s) requires but a facility fails to provide them, to the resident (s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Resident #4 was admitted to the facility on [DATE] post-acute care hospitalization . Diagnoses included Dysarthria following Cerebral Infarction, Encounter for Surgical Aftercare Following Surgery on the Circulatory System, Asthma, Heart Failure and Unspecified Atrial Fibrillation. On the Discharge Return Anticipated Minimum Data Set with an assessment reference date of 04/05/25 her Brief Interview for Mental Status was unable to be conducted which indicated she was severely cognitively impaired. Review of the Electronic Health Record (EHR) for Resident # 4 revealed she was admitted to the facility in the evening of 04/03/25. On 04/04/25 at 7:03 AM a nursing skilled documentation note revealed Pt is alert and responsive, Skin warm and dry. Breathing even and unlabored. All care provided by assigned staff; Turning and repositioning done per facility protocol. Call light in reach; Bed in low position. Care continues. On 04/04/25 skin/wound documentation revealed skin changes which were reported to the physician. On 04/04/25 she was also seen by the Dietitian, the activities assistant and the Medical Director. There was no documentation from the primary nurse on the first shift. On 04/05/25 at 8:10 AM nursing documentation revealed, Patient remain stable, no acute respiratory distress, no c/o pain or discomfort noted. Safety maintained, call light within reach. Plan of care continues. A review of the Medication Administration Record (MAR) for April 2025 revealed, the resident took her medications on 04/04/25 and at 6:00 AM on 04/05/25. The medications were marked as refused for the 9:00 AM medications. On 04/05/25 at 9:20 AM, Staff H, a Licensed Practical Nurse (LPN), documented that the resident refused her medications. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A record review of the Blood pressure (BP) for Resident #4 revealed: 4/5/2025 15:10 (3:10pm) -158 / 69 4/5/2025 09:19 - 101 / 82 4/4/2025 23:52 (11:52pm) 121 / 63 4/4/2025 10:04 - 116 / 58 4/4/2025 07:06 - 123 / 81 4/3/2025 19:12 (7:12pm) -115 / 83 A record review of the Pulse readings for Resident #4 revealed: 4/5/2025 15:10 - 78 bpm Regular (beats per minute) 4/5/2025 09:19 - 111 bpm Irregular - new onset 4/4/2025 23:52 - 61 bpm Regular 4/4/2025 10:04 - 68 bpm Regular 4/4/2025 07:06 - 71 bpm Regular 4/3/2025 19:13 - 68 bpm Regular The next entry into the nursing progress notes was on 04/05/25 at 2:45 PM which revealed, Resident transferred to [emergency room] ER for evaluation and treatment. Resident observed by nurse at the bedside nonresponsive verbally, but responsive to touch. Resident able to move all extremities [with] w/ weakness in left upper extremity from previous CVA. Resident vital signs were assessed BP 158/69, HR-78, [Oxygen Saturation] O2-96, [Respirations] R-16, [Blood Sugar] BS-158. Resident unable to verbally express if experiencing any pain. Resident assessed by Nurses X3, on shift supervisors X2 at the bedside. P.A. was immediately notified of changes. Orders received to transfer resident out to [WRMC, a local hospital] for evaluation and treatment. A review of the facility's transfer form revealed, the resident had altered mental status, was not alert, and was transferred to the hospital on 04/05/25 at 3:09 PM. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted with Staff J, a Certified Nursing Assistant (CNA) on 04/16/25 at 2:10 PM. Staff J stated she was the primary CNA for Resident #4 on 04/05/25. Staff J stated the resident was moving but not opening her eyes during her rounds between 7:30 AM-8:00 AM on 04/05/25. When breakfast came, she set up her tray, called her name and she was moving but not opening her eyes. She left the tray there and reported it to the nurse. She checked her brief which was dry, she did not give her personal care or dress her because her eyes were closed the whole morning. When lunch came, she brought her tray. She was still moving but not opening her eyes. She did not eat lunch. She did not drink anything. The nurse called Staff D, a Physician Assistant, (PA) and another nurse tried to put in an IV (intravenous line). The daughter came in and was upset and the resident was not alert. Paramedics came and she went to the hospital. A telephone interview was conducted with Staff D, PA, on 04/16/25 at 2:32 PM. She was asked if she was notified that Resident #4 refused her morning medication. She stated she was notified around 2-2:15 PM on 04/05/25 that she did not eat breakfast or lunch, so she assumed she did not take her medication. She stated she was on call and not in the building to evaluate the resident. An interview was conducted via telephone on 04/16/25 at 4:12 PM with Staff G, Registered Nurse (RN), Unit Manager. Staff G stated that she worked that day and there was another manager there that she was helping. She stated she was not aware at all that day that Resident #4 had not opened her eyes all day. She was not aware that the resident did not eat breakfast or lunch. At about 3:02 PM, Staff J asked her to check the resident, she was told a nurse was trying to start an IV on the resident. She stated she went into the room and there was froth in the resident's mouth. She checked her pupils, and they were deviating to the right. She thought she may have had another CVA (cerebral vascular accident/stroke). Just at that time, the resident's daughters came into the room very upset. The paramedics came at the same time and asked the primary nurse when the last time it was that she saw the patient awake and she stated when she gave report to the night nurse yesterday. A telephone interview was conducted with Staff I, RN on 04/16/25 at 4:20 PM. Staff I stated she was asked to put in an IV for Resident #4. She stated it was about 2:50 PM on 04/05/25. She entered the room and looked at the resident. She was making a snoring sound. She did not respond to a sternal rub. Her pupils were dilated but uneven. 911 was called and the daughter came. A telephone interview was conducted with Staff H, LPN, on 04/16/25 at 4:31 PM. She stated she has been working in this facility for a year. She stated she was the resident's nurse on 04/05/25. She also had her on 04/04/25 and on that day she was in the chair and using the white board to communicate. On 04/05/25 she went into Resident 4's room with Staff J to say good morning and she moved her arms and legs. She did not respond verbally. It appeared she was sleeping, snoring. She did her vitals, blood pressure and blood sugar and she responded to pain. She assumed she was tired. Around 8:00 AM-9:00 AM she could not give her meds. Then around 12:30 PM, Staff J noticed she did not eat lunch. She asked another LPN working on another hallway to do an assessment on Resident #4. That nurse did an assessment and thought she was really tired and weak but she was still moving her lips and arms and her blood sugar 188. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Staff H texted the PA at 12:30pm and said today she is not like herself and not as alert. The PA said to call the family to start an IV, stat chest x-ray, labs, and urine analysis. When asked if she asked the Unit Manager to check the resident, she stated that the Unit Manager was busy with another family at the time. She got a message from the receptionist that the daughter called around 1:30 PM. She called the daughter back about the change in condition and got the ok to start an IV. She asked Staff I to insert the IV. When she laid the resident back, the pupil assessment was unusual, and she texted the PA at 2:45pm to ask to send her to the hospital via 911. The two supervisors came into the room, the family came, and the paramedics came. The paramedics wanted to know when I saw her awake last, and I said she was sleeping this morning. They took her to the hospital. An interview was conducted with the Administrator on 04/16/25 at 3:24pm. The Administrator stated she was aware of Resident #4's condition on 04/05/25 since the resident's daughter had spoken to her about it on 04/07/25. On 4/5/2025, the resident was admitted to the Intensive Care Unit with a diagnosis of a CVA (Cerebrovascular Accident). A review of the hospital records for Resident #4 was conducted. A review of the History and Physical performed on Resident 4 on 04/05/25 at 5:33 PM, revealed the Glasgow Coma Scale results. The eye opening response was to pain, best verbal response was incomprehensible sounds, best motor response was flexes and withdraws to painful stimuli. The residents Glasgow Coma Score was 8. The Glasgow Coma Scale (GCS) is a system to score or measure how conscious you are. The highest possible GCS score is 15, and the lowest is 3. A score of 15 means you're fully awake, responsive and have no problems with thinking ability or memory. Generally, having a score of 8 or fewer means you're in a coma. The lower the score, the deeper the coma is. Facility staff did not recognize a decline in Resident #4's condition on 4/5/25 until approximately 12:30 PM on 4/5/25 and Resident #4 was transferred to the hospital at 3:09 PM.

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F 0684 Level of Harm - 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** 39026 Based on record reviews and interviews, the facility failed to ensure residents receive treatment and care in accordance with professional standards by failing to recognize one out of 2 residents sampled (Resident #5), after admission to the nursing home was not on medication for a diagnosis of Atrial Fibrillation. The resident was readmitted to the hospital with a diagnosis of Bilateral Pulmonary Embolism. The findings included: Resident #5 was admitted to the facility post-acute care hospitalization on [DATE]. Her admitting diagnoses included Staphylococcal Arthritis of Left Knee, Cellulitis of Left Lower Limb and Unspecified Atrial Fibrillation. Her Brief Interview for Mental Status was 15 on the 5-day Minimum Data Set with an assessment reference date of 03/12/25. This revealed the resident had intact cognition. A review of the Electronic Health Record (EHR) revealed the resident was evaluated by a nurse practitioner (NP) on 03/07/25. The NP note revealed was found with new onset of afib/aflutter- started on Eliquis. Pt stabilized and transferred to Luxe. Atrial fibrillation (Afib) is an irregular and often rapid heart rhythm that can lead to various complications, including blood clots, stroke, and heart failure. (Atrial flutter is an abnormal heart rhythm in the heart's upper chambers (atria). The atria beats too fast. This may cause dizziness and fatigue.) A review of the Eliquis prescriber information revealed Eliquis is an oral anticoagulant used to prevent and treat blood clots. Eliquis is used to lower the risk of stroke or a blood clot in people with atrial fibrillation. Premature discontinuation of any oral anticoagulant, including ELIQUIS, increases the risk of thrombotic events. If anticoagulation with ELIQUIS is discontinued for a reason other than pathological bleeding or completion of a course of therapy, consider coverage with another anticoagulant. On 03/09/25 the resident was seen by the same NP who wrote a progress note revealing the resident Was found with new onset of afib/aflutter- started on Eliquis. Pt stabilized and transferred to Luxe. In that same note the NP wrote Hospital/old records reviewed and new onset afib- on Eliquis. On 03/10/25 the pharmacist wrote a note revealing Medication Regimen reviewed: No recommendation made. On 03/11/25 a review of a physician note revealed Was found with new onset of afib/aflutter- started on Eliquis. The note continued to reveal I personally reviewed records including acute care hospital, skilled nursing facility, and therapy records. Summarization of the acute care course can be found in the HPI section. Discussed case with the primary medical team and/or leadership. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 03/11/25, the Medical Director wrote a progress note in the EHR revealing was found with new onset of afib/aflutter- started on Eliquis. Pt stabilized and transferred to Luxe. Hospital/old records reviewed, new onset afib- on Eliquis, dvt proph: Eliquis. (DVT is deep vein thrombosis and proph is prophylactic which indicates a drug used to prevent deep vein blood clots.) On 03/13/25 Staff D, a Physician Assistant (PA) wrote a progress note that revealed was found with new onset of afib/aflutter- started on Eliquis. Pt stabilized and transferred to Luxe. Hospital/old records reviewed, new onset afib- on Eliquis, dvt proph: Eliquis. On 03/14/25, the physician who wrote a note on 03/11/25 wrote another note revealing was found with new onset of afib/aflutter- started on Eliquis. Pt stabilized and transferred to Luxe. On 03/14/25 an APRN (Advanced Practice Registered Nurse) wrote a progress note that revealed was found with new onset of afib/aflutter- started on Eliquis. Pt stabilized and transferred to Luxe. On 03/15/25 a record review of Occupational Therapy (OT) notes revealed Patient reports feeling dizzy upon sitting EOB (edge of bed), before therapist could assist pt (patient) back to bed, pt passed out and was unresponsive x 30 sec (seconds). Pt regained consciousness, however diaphoretic and c/o (complained of) dizziness and possible passing out again. Pt's BP (blood pressure) =121/107. Pt's O2 (oxygen saturation) at 83 on room air. Pt placed on 2.5 liter O2 (oxygen) via face mask, after approximately 5 minutes, pt's O2 increased to 97%. Pt provided with cold was cloth. Nsg (nursing) staff assisted with pt and soon after pt was transported to hospital. A review of the March 2025 Medication Administration Record (MAR) indicated that the resident never received Eliquis while at the nursing home. A review of Physician orders revealed the resident never had an order for Eliquis at the nursing home. A review of the resident's care plan dated 03/10/25 revealed, The resident has altered cardiovascular status related to Hypertension, Hyperlipidemia and A-fib. Review of Resident #5's hospital records prior to admission to the nursing home which were included in the EHR revealed: Per hospital record documented on 03/05/25 - Cleared from cardiac standpoint. Stop heparin, restart Eliquis. Review of hospital records revealed AF/Flutter. New onset, was not in AF when she came in. TEE (transesophageal echocardiography which can detect blood clots in the heart) done no [NAME] (left atrial appendage which is a small sac in the muscle wall of the left atrium where blood could collect and form clots with someone with atrial fibrillation) clot. Cardioverted her during TEE but went back into rate controlled AF/ Flutter In and out of atrial flutter. Rate controlled. EF normal. Metoprolol Eliquis (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	TELE [Telemetry] : Atrial flutter Cleared for discharge FU [follow up] in office 2-3 weeks for [Paroxysmal Atrial Fibrillation] PAF/Atrial flutter The physician note revealed a cardioversion (a procedure that uses electrical shock to restore an irregular heartbeat to a normal rhythm) was done in the hospital prior to discharge. This was done during a TEE. The TEE revealed no [NAME] clot. EF (ejection fraction is a percentage of how much blood the ventricles pump out with each heart contraction). TELE (telemetry which monitors heart rate and rhythm). A telephone interview was conducted with Staff D, Physician Assistant (PA) on 04/16/25 at 2:32 PM. She was asked why her note, and every Physician and NP note revealed the resident was on Eliquis. She stated that it should have been picked up that the resident was not on Eliquis. It was not on the medication discharge list, and it should have been questioned. She probably wrote her note based on the previous notes. A review was done of the Hospital emergency room record from 03/15/25 and hospital records from the admission on 03/15/25 to discharge on 03/24/25 revealed, the resident was admitted to the hospital with a diagnosis of Bilateral Pulmonary Embolism. An Inairi pulmonary thrombectomy was performed on 03/18/25. A bilateral pulmonary embolism is a clot in the veins of both lungs that occurs when a blood clot that has arisen from a different area obstructs the pulmonary arteries. Mechanical thrombectomy, or simply thrombectomy, is the removal of a blood clot (thrombus) from a blood vessel. 50370