

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Luxe at Lutz Rehabilitation Center (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 19091 N Dale Mabry Hwy Lutz, FL 33548	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20311</p> <p>Based on observations, record review and interview, the facility failed to ensure the resident's right to privacy was upheld related to staff and visitors knocking at resident doors prior to entering for 3 of 36 (#51, #38 #55) sampled residents and 6 of 12 (Rooms 122, 123, 124, 127, 129, 130) random resident rooms on TCU unit.</p> <p>Findings included:</p> <p>1. During an interview with Resident #51 in her room on 04/16/24 at 09:01 AM Staff G, Certified Nursing Assistant (CNA) was observed to enter the resident's room without knocking. During an interview with Staff G at this time she reported that she usually knocks but because the room door was open, and she knows the resident is in the room she thought that it was ok.</p> <p>Review of Resident #51's electronic record revealed that she was admitted to the facility on [DATE] for orthopedic aftercare. Review of the residents Minimum Data Set (MDS) Brief Interview For Mental Status (BIMS) dated 3/19/24 revealed a score of 14 (Cognitively intact).</p> <p>2. During an interview with Resident#38 on 04/16/24 at 10:20 AM Staff E, Physical Therapist Assistant (PTA) entered the residents room without knocking and waiting to be invited in. During an interview with Staff E at this time she reported that she was sorry for entering the room without knocking, and that she should have knocked on the door.</p> <p>Review of Resident #38's electronic record revealed that she was admitted to the facility on [DATE]. Review of the residents MDS BIMS dated 3/22/24 revealed a score of 15 (Cognitively intact).</p> <p>3. Observations on 04/16/24 at 10:28 AM of the TCU hallways revealed a visitor with a dog going from room to room entering the rooms without first knocking. The visitor with the dog was observed to rooms 122, 124, 123, 127, 130, and 129 without knocking and waiting to be invited in by the residents. During the observation the visitor with the dog entered Resident #55's room without knocking and the resident was in the door bed told the visitor No, no I don't want dogs.</p> <p>Review of Resident #55's electronic record revealed that she was admitted to the facility on [DATE] for Hereditary and Idiopathic Neuropathy. Review of the residents MDS BIMS dated 4/11/24 revealed a score of 15 (Cognitively intact).</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 106093
		If continuation sheet Page 1 of 18

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Interview on 04/16/24 at 10:32 AM with Staff A, Licensed Practical Nurse (LPN), Unit Manager revealed that visitors and staff should be knocking at doors. She reported that everyone should knock on residents doors and wait to be invited in, and that this rule applies to all staff and all visitors. She reported that Pet Therapy should definitely knock on doors and wait to be invited in.</p> <p>Interview on 04/16/24 10:38 AM with Acting Activities Director revealed that dog therapy volunteers should be knocking on doors and waiting to be invited into the resident rooms. She reported that staff typically will walk around the facility with the dog therapy volunteers to ensure that they are not going into isolation rooms and to make sure that they do not go into rooms that resident do not like dogs.</p> <p>5. Review of the facility policy titled Resident Rights with an issued date of 09/2021 and a revised date of 01/2024 revealed the following:</p> <p>-A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents.</p> <p>-Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to:</p> <p>b. be treated with respect, kindness, and dignity;</p> <p>t. privacy and confidentiality;</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768</p> <p>Based on interview and record review, the facility failed to ensure the physician and resident representative was informed of medications not given as well as weights not performed for one of 40 sampled residents (#56).</p> <p>Findings included:</p> <p>Resident #56 was admitted on [DATE] and discharged to the hospital on 04/02/2024. Review of the admission record showed diagnoses included but were not limited to acute respiratory failure, pneumonitis due to inhalation of food and vomit, Chronic Obstructive Pulmonary Disease (COPD), heart failure, hypertensive heart disease with heart failure, malignant neoplasm of thyroid gland, secondary malignant neoplasm of liver and intrahepatic bile duct, secondary malignant neoplasm of lymph node, obesity, muscle weakness, and anxiety disorder.</p> <p>Record review of the admission Minimum Data Set, dated dated [DATE] showed Section C, Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact.</p> <p>Review of the physician orders and Medication Administration Record (MAR) and Treatment Administration Record (TAR) for March and April of 2024 showed:</p> <p>-Weigh resident daily x [times] 3 days then weekly x 4 months.</p> <p>-Acetazolamide 375 mg [milligrams] twice a day for elevated bicarbonate was ordered as of 03/27/2024. The MARs showed the medication was given on 03/27/24 p.m. and 03/28/24 both a.m. and p.m. Both of the 03/29/24 doses as well as the a.m. dose on 03/30/24 were shown as not given. The 03/30/24 p.m. dose as well as both doses on 04/01/24 and the a.m. dose on 04/02/24 were shown as given.</p> <p>Review of the Weights and Vitals Summary showed a weight on 03/19/2024 of 251.6 pounds.</p> <p>Review of Progress notes:</p> <p>-On 03/19/24 at 19:13, weigh resident daily x 3, weekly x 4 months; unable to obtain weight</p> <p>-On 03/20/24 at 20:10, weigh resident daily x 3, weekly x 4 months, unable to obtain weight</p> <p>-On 03/29/24 at 08:16: Acetazolamide 375 mg by mouth two times a day for elevated bicarb, medication on order (from pharmacy)</p> <p>-On 03/29/24 at 16:48 Acetazolamide 375 mg by mouth two times a day for elevated bicarbonate, on order (from pharmacy)</p> <p>-On 03/30/24 at 08:26 Acetazolamide 375 mg by mouth two times a day for elevated bicarbonate, awaiting pharmacy</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #56's care plans showed he had altered cardiovascular status related to Congestive Heart Failure (CHF), Hypertension, pneumonia and obesity. The Care plan was initiated on 03/18/2024. The goal was for the resident to be free from complications of cardiac problems. Interventions included but were not limited to Monitor vital signs / weights as ordered/ PRN (as needed). Notify MD of significant abnormalities/changes as ordered/indicated. Administer medications per MD order. Monitor/document/report PRN any changes in lung sounds on auscultation, edema and changes in weight.</p> <p>During an interview on 04/16/2024 at 12:12 p.m. Staff A, Licensed Practical Nurse (LPN) Unit Manager (UM), stated the resident came in with respiratory failure. He had been intubated and extubated while at the hospital. He was on oxygen at 4 liters per minute. She stated he was having some edema. The nurse was supposed to create a nursing note, if unable to obtain the weight, notify the physician and get a new order, if needed. Staff A, LPN, UM verified the weights were not performed on the 03/16/24, 03/17/24, 03/18/24 per the order. She stated the assigned nurse did not acknowledge or check off that the weight had been performed. The UM stated she walked the resident to the scale on 03/19/24 and weighed him herself. The resident was able to walk. She reviewed the TAR for 03/20/24, and verified it showed cannot obtain weight. She stated again he could walk to the scale. She stated she would expect to see the weights per the physician orders. The weights should have been performed on the March 16th, 17th, 18th, 20th, and 27th, and scheduled for April 3rd. The negative outcomes for not performing his weights included he had a diagnosis of CHF, fluid overload and respiratory failure with CHF. The medication Acetazolamide. was not in the Emergency Drug Kit (EDK), Lasix was. The LPN, UM stated for any medications not given, the physician should have been notified. She stated she would check the pharmacy slips as to why no more than two days of Acetazolamide was delivered. The LPN, UM provided a pharmacy slip which showed Acetazolamide 250 mg and 125 mg was delivered on 03/29/2024.</p> <p>Review of the facility's policy, Medication Administration, revised on 01/2024 showed 16. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document the rationale in the resident's medical record and notify the physician and responsible party, if indicated.</p> <p>Review of the facility's policy, Physician Orders, revised 01/2024 showed 1. Medication shall be administered upon the written order of a person duly licensed and authorized to prescribe such medications in this state as soon as practicable. 9. Physician orders should be followed as prescribed, and if not followed, the reason should be recorded on the resident's medical record during the shift. The physician should be notified and responsible party if indicated.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48823</p> <p>Based on record reviews, and interviews, the facility failed to confirm the accuracy of the Pre-Admission Screening and Resident Review (PASRR) and to correct the document for six (#2, #24, #43, #49, #238, and #388) out of twenty-four residents sampled.</p> <p>Findings Included:</p> <p>1. An interview with the Assistant Director of Nursing (ADON) was conducted on 4/18/2024 at 12:30 PM. The ADON stated that the facility does not have a policy and procedure for completing the PASRR.</p> <p>Review of the clinical record for Resident #24 revealed:</p> <p>-Review of the electronic medical record/admission record dated 4/18/2024 showed that Resident #24 was originally admitted on [DATE] and most current admission on 11/20/2023.</p> <p>-Review of the electronic medical record/admission record dated 4/18/2024 revealed the following diagnoses for Resident #24: Traumatic hemorrhage of the cerebrum, dementia, Schizoaffective disorder, major depressive disorder, anxiety disorder.</p> <p>-Review of the electronic medical record/physician orders dated 4/18/2024 for Resident #24 revealed: monitor side effects of anti-depressant medications, monitor behaviors, consult psych services and or psychology as needed, monitor effects of psychotropic medications, pain management monitoring, trazodone for depressive disorder,</p> <p>Review of electronic medical record/Minimum Data Set (MDS) dated [DATE] for Resident #24 revealed.</p> <p>-Section A - Identification information - entry date 11/20/2023, observation date 2/15/2024</p> <p>-Section C - Cognitive Patterns - Brief Interview for Mental Status (BIMS) score of 15</p> <p>-Section I - Active Diagnoses - non-Alzheimer's dementia, traumatic brain injury (TBI), anxiety disorder, depression, schizophrenia,</p> <p>-Section N - medications - antidepressant is taking, and indication noted,</p> <p>Review of electronic medical record/PASRR Level I dated 4/3/2024 for Resident #24 revealed:</p> <p>-Section I - A anxiety disorder and depressive disorder checked. B. finding based on documented history and medications checked. Section IV - no diagnosis or suspicion of serious mental illness or intellectual disability indicated. Level II PASRR evaluation not required.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of electronic medical record/care plan focus for Resident #24 revealed: discharge planning, pain management, advanced directive, Compliance with medications related to diagnoses of schizoaffective disorder, dementia, and anxiety disorder, impaired cognitive functioning/impaired thought processes related to diagnoses of dementia, anxiety disorder, and schizoaffective disorder, mood management related to diagnoses of depression, anxiety, and schizoaffective disorder and medication use.</p> <p>Review of electronic medical record/psychoactive medication consent dated 3/12/2024 for Resident #24 for the medication trazodone.</p> <p>An interview was conducted with the ADON on 4/18/2024 at 12:30 PM. The ADON stated that the Level I PASRR did not have the correct information documented and the diagnoses of schizoaffective disorder was absent, and level II should be completed.</p> <p>39438</p> <p>2. A review of the Admission Record showed Resident #2 was initially admitted to the facility on [DATE] with diagnoses of anxiety disorder and bipolar disorder.</p> <p>The Admission Record revealed a new diagnoses of adjustment disorder with anxiety on 06/22/20, major depressive disorder on 01/04/21, and persistent mood disorder on 06/01/21.</p> <p>Review of Resident #2's PASRR Level I Screen dated 04/03/24 and completed by the Assistant Director of Nursing (ADON) only showed a qualifying diagnosis of anxiety disorder and indicated no PASRR Level II was required.</p> <p>On 04/18/24 at 11:42 a.m., the ADON reported they started doing audits on PASRRs because there were a lot of diagnoses not listed on the PASRRs. She confirmed she completed the PASRR for Resident #2 during the audit. She confirmed that all her current diagnoses were not listed on the PASRR. She stated she only looked at physician orders to complete the PASRR and not the list of diagnoses.</p> <p>On 04/18/24 at 1:30 p.m., the Director of Nursing (DON) reported that PASRRs were not complete and accurate, so they started doing audits. They started the audits on 03/08 and they were reviewed by the clinical team. The concern with Resident #2's PASRR was reported, and he stated he would have to readjust the audits to look at all diagnoses as well.</p> <p>48441</p> <p>3. A review of the admission face sheet for Resident #43 revealed an admitted [DATE] with a primary diagnosis of osteomyelitis of vertebra lumbar region. Secondary diagnosis included but not limited to alcoholic cirrhosis of liver without ascites, generalized anxiety disorder, and unspecified depression.</p> <p>A review of the care plan dated 4/09/24 has focus of uses anti-anxiety medications related to anxiety disorder, at risk for complications associated with long term use at risk for falls with sedative effects of medications. Resident # 43 was care planned with the following focus: at risk for alteration in mood and /or behavior related to diagnosis of depression and anxiety and the goal to have a stable mood without signs of symptoms of depression, anxiety, or sadness.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of physician orders includes the following but not limited to: Citalopram Hydrobromide oral tablet 40 milligrams (mg) to give one tablet by mouth one time a day for depression; Mirtazapine oral tablet 15 mg to give one tablet my mouth at bedtime for depression; Alprazolam oral tablet 0.5 mg to give one tablet by mouth every twelve hours related to generalized anxiety disorder.</p> <p>A review of the Preadmission Screening and Resident Review (PASRR) dated 3/13/2024 Section I: PASRR Screen Decision -Making Section A. Mental Illness or suspected Mental Illness does not have anxiety, depression nor alcohol dependency checked.</p> <p>A review of the admission face sheet for Resident #49 revealed an admitted [DATE] with a primary diagnosis of osteomyelitis of vertebra lumbar region. Secondary diagnosis included but not limited to unspecified depression and generalized anxiety disorder.</p> <p>A review of the admission care plan has a focus on mood problems related to mood disorder, depression, and anxiety, with the goal to have a stable mood without signs of symptoms of depression, anxiety, or sadness.</p> <p>A review of the Preadmission Screening and Resident Review (PASRR) dated 4/03/2024 Section I: PASRR Screen Decision -Making Section A. Mental Illness or suspected Mental Illness does not have depression checked.</p> <p>A review of the admission face sheet for Resident # 238 revealed an admitted [DATE] with a primary diagnosis of Parkinson's disease without dyskinesia without mention of fluctuations. Secondary diagnosis include but are not limited to neurocognitive disorder with Lewy Bodies, generalized anxiety disorder, unspecified depression, and post-traumatic stress disorder (PTSD).</p> <p>A review of the admission care plan initiated 4/09/24, has a focus for at risk for alteration in his mood and/or behavior related to diagnosis of depression, Lewy Body dementia, Parkinson's disease, PTSD, and insomnia.</p> <p>A review of the Preadmission Screening and Resident Review (PASRR) dated 3/25/2024 Section I: PASRR Screen Decision -Making Section A. Mental Illness or suspected Mental Illness does not have depression, anxiety, PTSD checked.</p> <p>50434</p> <p>4. Review of Resident #388's admission record showed Resident #388 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, unspecified severity, with other behavioral disturbance, and depression, unspecified.</p> <p>The level I PASRR dated 04/05/2024 showed in Section I-part A MI (Mental Illness) or suspected MI (Mental Illness) check all that apply was blank.</p> <p>Section II: Other Indications for PASRR Screen Decision-Making questions 1 through 7 were marked no.</p> <p>Section III: PASRR Screen Provisional Admission or Hospital Discharge Exemption Not a Provisional Admission was marked.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Section IV: PASRR Screen Completion, Individual may be admitted to a Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required was marked.</p> <p>Registered Nurse (RN) from St Joseph's Hospital North signed and completed the PASRR on 04/05/2024.</p> <p>Interview on 04/18/2024 at 11:50 a.m. with ADON stated she just started handling the PASRR. The ADON reviewed resident #388's PASRR and confirmed the PASRR was not completed and should have been corrected at admission of resident #388.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20311</p> <p>Based on observations, record review and interview, the facility failed to provide Activities Of Daily Living (ADL) for 2 of 3 (#10, #55) residents sampled for ADL care related to personal hygiene.</p> <p>Findings included:</p> <p>1. Observations of Resident #55 on 04/16/24 at 12:52 PM the resident was observed sitting up in her bed eating her midday meal. The resident was noted with gray facial hair on her chin. Interview with Resident #55 at this time revealed that she does not like having the hair on her face and that no one has offered to assist her with removing the facial hair.</p> <p>Observations on 04/17/24 at 09:08 AM revealed Resident #55 sitting up in her bed. The resident indicated that it's still there! as she wiped her hand over her chin. The resident reported that they still have not shaved her.</p> <p>Review of Resident #55's electronic record revealed that she was admitted to the facility on [DATE] with diagnosis that included muscle weakness, Osteoarthritis, and Spinal stenosis. Review of the residents Minimum Data Set (MDS) Brief Interview For Mental Status (BIMS) dated 4/11/24 revealed a score of 15 (Cognitively intact).</p> <p>Review of the residents Admission Nursing Evaluation dated 3/22/2024 revealed that the resident had an Occupational Therapy referral with interventions that included a. ADL training hygiene/grooming</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] revealed that the resident has impairment on both sides of her upper extremities. the MDS indicated that the resident is dependent for shower/bathing self</p> <p>Review of resident #55's care plan revealed a care plan dated 3/22/24 related to ADL self-care deficit r/t weakness d/t dx: neuropathy, lumbar stenosis, obesity. The care plan included interventions to:</p> <p>Encourage and assist with all ADL tasks as indicated, as tolerated by resident, including locomotion/ambulation, bathing, bed mobility, transfers, toileting tasks, meals, personal hygiene, etc.</p> <p>ADL care: Assist Resident #55 x1 or x2 for ADL care. This may fluctuate with weakness, fatigue, and weight bearing status.</p> <p>Interview on 04/17/24 at 09:14 AM with Staff H, CNA revealed that she is assigned to this resident. She reported that she assists residents with bathing, grooming, and transferring. Staff H reported that residents have scheduled showers 2 times a week and can request a shower at any time. She reported that she will shave men as part of their grooming if needed and that sometimes shave women if it is needed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Staff A Licensed Practical Nurse (LPN), Unit Manager on 04/17/24 at 09:17 AM revealed that residents get scheduled showers twice weekly. She reported that there is no set time to shave residents but for female residents when you see the hair they should be assisted with shaving if they want it.</p> <p>Interview on 04/17/24 at 09:35 AM with the Director of Nursing (DON), revealed that his expectation related to grooming that residents receive at least 2 showers a week, that they can ask for more. He reported that he expects that as tolerated staff will wash hands and face, comb their hair, and would expect that on those days the resident would get a shave based on their preference. The DON reported that this applies to everyone. The DON reported that the CNA would identify the need for a shave, and it would be reasonable for staff to ask the resident if they would like to be shaved. He reported that staff should know to refer to the Kardex. The DON reported that nurses should identify that something needs to be done and direct the CNA's to do it, if the resident declines then the CNA should make the nurse aware.</p> <p>50434</p> <p>2. Observation and Interview on 4/15/2024 at 11:05 am resident #10 was observed in her bed dressed in a gown. The resident was observed to have strands of white facial hair on her chin. Resident #10 at this time revealed that she does not like the hair on her chin and that she would like the facial hair to be gone. Otherwise, she is happy and feels like she is well taken care of, and she has no concerns.</p> <p>Observation and Interview on 4/16/2024 at 9:45 am resident #10 was observed in bed in a gown watching tv. Resident was happy in nature. She was observed to have strands of white facial hair on her chin. The resident reported that the staff have helped her get washed up, but that no one has asked or offered her assistance with the hair on her chin.</p> <p>Review of Resident #10's record revealed that the resident was admitted to the facility on [DATE] and had diagnosis that included muscle weakness, morbid (severe) obesity due to excess calories, dysphagia, oropharyngeal phase.</p> <p>Review of the residents 5-day Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 06 (Moderate Cognitive Impairment). Continued review of the MDS revealed that the Resident is dependent with substantial/maximal assist with Shower bath self.</p> <p>During an Interview on 04/17/2024 at 9:45a staff B, Certified Nursing Assistant (CNA) stated she helps residents with their daily living activities such as brushing teeth, changing clothing, taking showers, and combing hair. She stated if a resident would like to be shaved, they just must ask her so that she is aware of their preferences.</p> <p>During an interview on 04/17/2024 at 2:15p with staff A, Licensed Practical Nurse (LPN) stated that CNA's provide care for the residents on the floor. They assist residents with dressing, bathing, shaving, brushing teeth and combing hair. She stated that if residents need to be shaved, they will help them upon the request of the resident.</p>		

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NAME OF PROVIDER OR SUPPLIER Luxe at Lutz Rehabilitation Center (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 19091 N Dale Mabry Hwy Lutz, FL 33548	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20311</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 39 (#340, #389) sampled residents received treatment and care in accordance with professional standards of practice related to unlabeled dressings.</p> <p>Findings included:</p> <p>Review of the facility policy titled Wound Care and Treatment with an issue date of 03/2020 and a revised date of 01/2024 revealed the following:</p> <p>13. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initial, time, and date and apply to dressing.</p> <p>1. Review of Resident #340's record revealed that this resident was admitted to the facility on [DATE] with diagnosis that included: hemiplegia and hemiparesis following cerebral infraction affecting right side. Review of the residents physician orders revealed orders with a start date of 4/15/24 and an end date of 4/16/24 for [bloodwork/labdraws]in AM every night shift for 1 day</p> <p>Observations of Resident #340 on 04/16/24 at 09:12 AM revealed the resident lying in bed. Attempt to communicate with the resident was unsuccessful. During the observation the resident was noted with a dressing to his left hand which was unlabeled/undated. (Photographic evidence obtained).</p> <p>Interview on 04/16/24 at 10:40 AM with the resident's spouse in person and resident's son on phone revealed the resident was admitted to the facility yesterday and was very confused about his surroundings. They reported that he did not arrive to the facility with a dressing to his left hand that it must have been put on after he was admitted .</p> <p>Interview with Staff A, Licensed Practical Nurse (LPN), Unit Manager revealed that she is not sure about the dressing the resident is a new admission and may have received bloodwork.</p> <p>50434</p> <p>2. During Observation and Interview on 4/15/2024 at 11:00 am, resident #389 was observed sitting in his wheelchair dressed for the day. The resident was observed with bandages on his right leg and right arm which he states they are taking care of but not as well as he would hope. He states the bandages just fall off. The bandages to his right elbow and right arm were not dated. The bandages to his right and left lower legs were labeled with a date of 4/12.</p> <p>During Observation and Interview on 04/16/2024 at 9:30 am, resident #389 was observed lying in bed. He stated it was a little loud the previous night, so he was still resting. The resident had 3 Bandages to his right upper arm, on his right elbow and on his right forearm. All three of the bandages were white and were not dated. He also had bandages on his right and left lower legs that were not dated.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #389's active physician orders showed a physician order dated 04/02/2024 for, cleanse right knee, left Knee, posterior left ankle, and right elbow with NS [normal saline], pat dry, apply xeroform, cover with border dressing QOD [every other day] and PRN [as needed] every day shift every other day for skin tear and as needed for skin tear.</p> <p>A review of the Treatment Administration Record (TAR) for April showed the same orders of cleanse right knee, left Knee, posterior left ankle, and right elbow with NS, pat dry, apply xeroform, cover with border dressing QOD and PRN every day shift every other day for skin tear and as needed for skin tear. The TAR showed the treatment was completed for 7 out of the 8 instances.</p> <p>During an Interview on 04/18/2024 at 9:45 AM, with Staff B, Registered Nurse (RN) states nurses are responsible for bandage changes; she says they use the orders in [name of electronic medical record] to know how often to change the bandages and what type of dressing and cleaning solution to use. She stated bandages are to be labeled with the date the bandage was applied to the resident.</p> <p>Interview on 04/18/2024 at 2:00p with Director of Nursing (DON) states he expects the nurses to follow the orders for the patient that are in [name of electronic medical record]. He stated it is expected of the nurses to label bandages with the correct date when they are changed.</p> <p>Interview on 04/18/2024 at 2:40p with Staff A, Unit Manager (UM) states she expects the nurses to follow the orders and their facility protocols for each resident. She stated their facility protocol is to label bandages each time they are changed.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>48441</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure the medication error rate was less than 5.00%. Forty-four medication administration opportunities were observed and fourteen errors were identified for three residents (#42, #241, #24) of eight residents observed. These errors constituted a 25% medication error rate.</p> <p>Findings include:</p> <p>On 4/17/24 at 8:45 a.m., medication administration observations were made with Staff J, Licensed Practical Nurse (LPN) for Resident # 42. The staff member dispensed the following medications:</p> <ul style="list-style-type: none"> -Amiodarone 200 milligram (mg) one tablet -Plavix 75 mg one tablet -Lasix 20 mg one tablet -Potassium chloride 10 milliequivalent (mEq) one tablet -Ferrous Sulfate 325 mg one tablet <p>During observation and interview, Staff J, LPN stated the resident has Metoprolol 12.5 mg and Eliquis 2.5 mg due but there were none available in the medication cart. Staff J, LPN wrote on a notepad the two missing medications and administered the medication pulled above to the resident and informed the resident two medications are not available currently. Staff J, LPN stated because she is agency, she does not have the key to the locked medication room to obtain missing medications and she will let the Unit Manager know whenever she sees her. Staff J, LPN stated the notepad is her way of keeping a list of missing medications.</p> <p>On 4/17/24 at 10:40 a.m., an interview was conducted with Staff J, LPN regarding medication for Resident #42. Staff J, LPN stated she was complete with her medication administration for her hallway. Staff J, LPN admitted to not administering or following up with Resident #42's medication. Staff J, LPN stated the medications should be requested electronically through the electronic Medication Administration Record. Staff J, LPN stated the Eliquis was ordered on 4/14/24 but could not state why the medication had not been in the medication cart. Staff J, LPN ordered the Metoprolol as a demonstration on how to send a message to the pharmacy team. The Metoprolol was not requested until Staff J, LPN stated she forgot to put the request in earlier and forgot to inform the Unit Manager to inform of the missing medication for Resident #42 but will do this now.</p> <p>On 4/17/24 at 10:50 a.m., an interview was conducted with Staff L, Registered Nurse/Unit Manager (RN/UM). Staff L, RN/UM was not aware of Resident #42 missing two medications. Staff L, RN/UM stated if Staff J, LPN had informed her of the missing medications, she would have assisted the nurse to access the medication emergency supply and contact the physician of the delayed administration.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #42's April Medication Administration Record (MAR) identified the resident was to be administered Metoprolol Succinate ER Oral Tablet extended Release 24 hour, give 12.5 mg by mouth in the morning for hypertension hold if systolic blood pressure is less than 110 or heart rate less than 60, swallow whole due at 0900, and Eliquis Oral Tablet (Apixaban) Give 2.5 mg by mouth every morning and at bedtime related to paroxysmal atrial fibrillation scheduled for 0900 and 2100.</p> <p>On 4/17/24 at 10:09 a.m., medication administration observation was made with Staff K, LPN for Resident # 241. The staff member dispensed the following medications:</p> <ul style="list-style-type: none"> -Levemir 30 units SQ -Tylenol 325 mg two tablets -ASA 81 mg enteric coated one tablet -Pepcid 10 mg two tablets -Amiodarone 2.5 mg one tablet -Eliquis 2.5 mg one tablet -Lasix 40 mg- one tablet -Lisinopril 20 mg one tablet -Metoprolol 50 mg one tablet <p>Staff K, LPN stated Calcium Carbonate or TUMS was due as well but stated she does not have any in her cart. After administration of currently pulled medication and insulin, Staff K, LPN returned to her cart and began to talk to the Nurse Practitioner waiting for Staff K regarding Resident #241. Staff K, LPN took a verbal order for new medications for Resident #241 and started to move the medication cart to the next resident for administration. When asked if the medication was complete for Resident #241, Staff K, LPN stated yes.</p> <p>A review of Resident #241's April (MAR) has Vitamin D3 capsule 400 unit give one capsule by mouth two times a day for supplement and Calcium Carbonate tablet 600 mg give one tablet by mouth two times a day for supplementation both to be administered by 0900. All the medications administered had a 09:00 administration time.</p> <p>On 4/18/24 at 9:25 a.m., medication administration observation was made with Staff M, RN for Resident # 24. The staff member dispensed the following medications:</p> <ul style="list-style-type: none"> -Acidophilus 500 million- one tablet -Caltrate 600 mg -one tablet -Ferrous Sulfate 325 mg -one tablet <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Hydroxychloroquine sulfate 200 mg one tablet</p> <p>-Thera -M one tablet</p> <p>-Colace 100 mg one tablet</p> <p>-Minocycline HCL 100 mg - one tablet</p> <p>-AREDS -one tablet</p> <p>-Norvasc 10 mg gave 4 tablets of 2.5 mg</p> <p>A review of Resident #24's April (MAR) has Sodium Chloride (NaCl) Tablet Give 2 gram by mouth every morning and at bedtime for Hyponatremia. Staff M, RN did not have NaCl tablets in medication cart and a request was made to the UM, Staff L. Staff L returned with Sodium Bicarbonate as the only medication available throughout the facility. Staff M, RN refused stating the medications are not the same. Staff L, RN/UM stated the medication was eventually purchased by their Regional Nurse Consultant at a local pharmacy down the street.</p> <p>On 4/17/24 at 11:05 a.m., an interview was conducted with the Director of Nursing regarding the missing medications, over the counter medications' availability and the timeliness of medication administration. The DON agreed agency nurses do not have access to the emergency administration cart for safety reasons and accountability. The DON agreed multiple factors contribute to timeliness and is working on educating staff to focus solely on medication administration and to avoid distractions.</p> <p>A review of the facility's policy entitled, Standards and Guidelines: Medication Administration, revised January 2024 state the following standard: medications are ordered and administered safely and as prescribed.</p> <p>.</p> <p>3. Medications are administered in accordance with prescribed orders, including any required time limit.</p> <p>.</p> <p>6. Medications are administered within one hour before or after their prescribed time, unless otherwise specified (for example, before and after meal orders, at bedtime).</p> <p>.</p> <p>19. Staff follows established facility infection control procedures hand washing, aseptic technique, gloves, isolation precautions, for the administration of medications, as applicable.</p> <p>.</p> <p>22. Medications will be reordered as needed with practitioner approval unless otherwise indicated, for example, auto refill from pharmacy, emergency medication supply use, etcetera.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20311</p> <p>Based on observation, record review and interview, the facility failed to ensure it had an effective infection control program related to hand hygiene on 2 of 4 units (TCU, Lakeview) , sharps containers, and use of Personal Protective Equipment (PPE) for one of one residents on Transmission Based Precautions (#184).</p> <p>Findings included:</p> <p>1. Observations of meal distributions on TCU unit from 04/15/24 at 12:48 PM revealed that the meal cart arrived on the unit. Continued observations at this time revealed that that Staff I entered random rooms to deliver meal trays. Staff I was not observed to sanitize or wash his hands. Additional observations revealed the following:</p> <p>-04/15/24 at 12:52 PM Staff I entered room [ROOM NUMBER] (enhanced barrier room) and delivered a meal tray. No hand sanitizing or washing noted before entering the room or after exiting the room.</p> <p>-04/15/24 at 12:48 PM Staff I delivered meal tray to room [ROOM NUMBER]. No hand sanitizing or hand washing noted before entering the room or after exiting the room.</p> <p>-04/15/24 at 12:55 PM Staff I took two trays into room [ROOM NUMBER], adjusted resident in the window bed, and then set up the resident's tray. Staff I then proceeded to set up the meal tray for the resident in the door bed with no hand sanitizing or handwashing noted.</p> <p>-04/15/24 at 12:57 PM Staff I entered room [ROOM NUMBER], set up the meal tray for the resident in the door bed, after physically interacting with the resident in the window bed. Staff I was not observed to sanitize or wash his hands before entering the room or after exiting the room.</p> <p>Interview on 04/15/24 at 1:05 PM with Staff I, CNA revealed that he is a CNA on the TCU unit and loves working with the residents and helping them. Staff I said he was not aware that he did not sanitize his hands at any time during meal distribution.</p> <p>Review of the facility policy titled Hand Hygiene Infection Control with an issue date of 10.2014 and a revised date of 6.2023 revealed the following:</p> <p>-This facility shall require facility personnel used accepted hand hygiene after each direct resident contact for which hand hygiene is indicated.</p> <p>-Situations that require hand hygiene include, but are not limited to:</p> <p>Before and after direct contact (for which hand hygiene is indicated by acceptable professional practice)</p> <p>Before and after assisting a resident with meals</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Observations of the Lakeview nurses station on 04/15/24 at 11:03 AM revealed a medication cart parked in close vicinity of the nurses station. The medication cart was locked with no staff person present in the area. Closer observation of the medication cart revealed that it had a sharps container attached to the right side of the cart directly above the mounted trash can. The sharps container was noted to be full of items visible and reachable and the flap was unable to be closed due to the container being full.</p> <p>Observations of the Lakeview nurses station on 04/15/24 at 12:44 PM revealed that a medication cart was still parked in close vicinity to the nurses station, and that the sharps container was still full and open with sharps accessible to all.</p> <p>An interview at this time with the Director of Nursing (DON) revealed that the sharps container was full, that nothing should be reachable in the container, and that the flap on the container should be closed.</p> <p>Review of the facility policy titled Sharp Disposal with an issue date of 02/2019 and a revised date of 01/2024 revealed the following:</p> <p>-Guideline: To provide storage of potentially hazardous supplies and to minimize the potential risk of sticks caused by used needles.</p> <p>48441</p> <p>3. On 4/15/24 at 9:45 a.m., an observation and interview were conducted Resident #184, who was on Contact Isolation. The outside of the resident's room had a sign indicating the following instructions: wash hands, wear gown and glove prior to entering room with an additional instruction for visitors to ask the staff if there were any questions or concerns. Upon entering the room, the resident stated the staff does not wear personal protective equipment (PPE) when entering her room. Upon doffing PPE there was no proper size garbage pail located in the resident's room and subsequently utilized a small waste pail basket located in the resident's bathroom.</p> <p>On 4/17/24 at 10:09 a.m., an observation and interview were conducted during medication administration for the resident on Contact Isolation. Staff K, Licensed Practical Nurse entered the resident's room without wearing appropriate PPE indicated on the Contact Isolation sign outside of the resident's room. When Staff K, LPN was asked about the instructions for isolation and what should be worn, Staff K, LPN read the sign and stated this is for family and visitors only. Staff K, LPN administered medication to resident without wearing the stated PPE on the sign.</p> <p>On 4/17/24 at 10:28 a.m., an interview was conducted with the Infection Control Preventionist/Assistant Director of Nursing (ICP/ADON). The ICP/ADON stated all entering the resident's room must wash their hands and don a gown and gloves. The ICP/ADON stated this is the only resident in the facility to be in contact isolation and education is needed for the entire facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/15/24 at 12:03 p.m., an observation was made of lunch in the main dining room. Observations of hand hygiene among staff in between passing and setting up lunch for residents were sporadic. Three unidentified residents refused the main entry and Staff N, Certified Nursing Assistant/Activities offered peanut butter and jelly sandwiches to these residents. One unidentified resident required assistance with the sandwich. Staff N, CNA/Activities unwrapped the sandwich and proceeded to cut the sandwich into bite size pieces, using her bare left hand to hold down the sandwich.</p> <p>50434</p> <p>4. Observation on 04/15/2024 at 12:53p Staff C, Certified Nursing Assistant (CNA) was observed entering residents' rooms passing lunch trays. Staff C, CNA was observed entering a resident's room raising the bed, moving the bedside table, she exited the room, went to the cart where the lunch trays were being held, grabbed another tray, and continued to the next resident's room. She continued this pattern down hall passing lunch trays without performing hand hygiene in between residents.</p>