STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106148	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luxe at Jupiter Rehabilitation Center (the)	674 Pioneer Road Jupiter, FL 33458

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29151 Based on record review and interview, it was determined, the clinical staff failed to complete an assessment after a resident sustained an injury; failed to obtain and report all pertinent information to the provider to ascertain the best course of treatment; failed to complete an incident report after the injury was reported by the resident; and failed to complete an investigation to determine if the resulting injury, a fractured wrist, met the criteria for an adverse event. These failures affected 1 of 3 sampled residents (Resident #1). The findings included: Clinical record review revealed Resident #1 was admitted to the facility for rehabilitation services on 02/10/24. Review of the Fall risk assessment dated [DATE] revealed the resident was assessed at high risk with a score of 12 (a score greater than 10 deems the individual as high risk). Review of the Minimum Data Set admission assessment with reference date 02/13/24 documented the resident was assessed as independent for skills of daily decision making; was occasionally incontinent of bladder, had occasional pain, shortness of breath while lying flat or with exertion and had no prior falls. The resident was receiving antibiotic, antidepressant, antiplatelet, hypoglycemic, diuretic and anticoagulant medications. Resident #1's Care Plan dated 02/17/24 documented the resident is at risk for falls related to impaired hearing, impaired vision, unsteady gait, poor balance, use of antihypertensive medications and use of psychotropic medications. The resident potential for sustaining a fall-related injury will be minimized by utilizing fall precautions/interventions though next review date. The interventions included: o Encourage and assist resident to use bed in the lowest position as tolerated. o Encourage and assist the resident to increase activity participation. (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Encourage and assist the resident to wear appropriate footwear such as rubber-soled shoes, non-slip bedroom slippers, non-skid socks, etc. when ambulating, transferring, or mobilizing in wheelchair. o Encourage and remind resident to use the call bell and to wait for staff assistance with transfers, ambulation, toileting, etc. as indicated. Review of Progress Notes dated 02/19/24 documented, Resident was observed in his room, hold her wrist swollen. Resident unable to give description. Supervisor notified. ARNP (Nurse Practitioner) made aware, X-ray ordered. At Approximately 12:50, resident transferred to Hospital for evaluation. ARNP called and family notified. Progress Notes dated 02/20/24 documents Around 0600 resident came back from the hospital with a Colles fracture. ARNP made aware. Resident alert and oriented. Further review of Progress Notes dated 02/20/24 documented, Held Care Plan meeting with resident at bedside. Was able to tell me the events of her fall & wrist fracture last evening. States she was cold and was getting a sweater from her drawer. She turned & fell . Instructed to please call for assist as needed and especially nighttime hours, and call for staff assist with temperature control as needed. Verbalized understanding Denied any acute pain. Splint/ace wrap present to right forearm. Review of Physician Notes dated 02/20/24 documented, CHIEF COMPLAINT: Mobility and activity of daily living dysfunction secondary to Clostridium Difficile Colitis and Congestive Heart Failure exacerbation, now with medical debility . Reportedly had a fall with Right Colle's fracture, placed in splint. Patient reports right upper extremity pain has been tolerable, worse with movements. Review of the incident logs dated 01/01/24-04/01/24 failed to include Resident #1's fall on 02/19/24. Further review of the clinical record failed to provide evidence the nursing staff completed a post fall assessment. Interview with the Regional Nurse Consultant conducted on 04/02/24 at 10:26 AM confirmed there was no incident report for Resident #1. Interview with the Nurse Practitioner (ARNP) conducted on 04/02/24 at 10:33 AM revealed she recalls the nursing supervisor calling her and reported the resident was having pain to her wrist, the resident reported having a fall, and she then ordered an x-ray. The patient did not want to wait for the x-rays at the facility and was sent to the emergency room and returned with a diagnosis of a fractured wrist. The ARNP verbalized no other details of the injury were provided during the call. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator conducted on 04/02/24 at 10:40 AM revealed there is no report of a fall; no one witnessed the fall, the resident was just complaining of wrist pain, and they called the ARNP and sent her to the hospital. The Administrator was asked if so, did they report an injury of unknown origin, as the resident sustained a fracture and replied there is no report on file. Interview with the Director of Nursing (DON) conducted on 04/02/24 at 10:42 AM revealed she did not know anything about the incident. Interview with the Care Plan/MDS Registered Nurse conducted on 04/02/24 revealed she was doing her routine care plan meeting on 02/20/24 and the resident verbalized to her that last night, she had a fall and sustained a fracture. The Nurse stated she did not report the fall, as she assumed that everyone else knew about the incident. Interview with the Evening Supervisor conducted on 04/02/24 at 12:06 PM revealed she had no specific recollection of this resident but explained, if the nurses report falls or injuries she text the ARNP and they will tell her how to proceed, and will put the orders in the computer. The nurses are responsible for doing their assessment and documentation. The Supervisor explained she would assess residents if is something is really bad, she does not assess every event, if she did she will not get anything else done. The supervisor was unable to recall any further details about the event. Interview with the Regional Nurse Consultant conducted on 04/02/24 at approximately 12:30 PM revealed the facility does not have a policy regarding incident reports, event investigations or adverse events, the facility follows the regulations. Interview with the Director of Nursing, Assistant Director of Nursing, Regional Nurse Consultant and Administrator conducted on 04/02/24 at 1:11 PM confirmed after review of the clinical record, there was no evidence that a nursing assessment was completed after the injury was reported; there is no incident report; there is no investigation of the event and there are no statements from the staff involved. Interview with the Aide assigned to care for Resident #1 on 02/19/24 was conducted on 04/02/24 at 4 PM. The Aide had no recollection of the resident at all and was unable to answer any questions. Multiple attempts to interview the primary nurse on 04/02/24 were unsuccessful. Based on record review and interview, the facility staff failed to assess Resident #1 after reporting an injury. The nurses contacted the ARNP and reported minimal information to determine whether the resident required immediate care or the injury could wait for the provision of inhouse x-rays. The nurses failed to complete an event report to ensure all the details surrounding the injury were documented to aid with the investigative process. The facility failed to investigate the fall and therefore, failed to determine if the injury met the criteria for an adverse event.