

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/30/2024
NAME OF PROVIDER OR SUPPLIER  Luxe at Jupiter Rehabilitation Center (the)		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>29151</p> <p>Based on record review, policy review and interview, the facility staff failed to immediately report an allegation of abuse involving 1 of 2 sampled residents (Resident #1).</p> <p>The findings included:</p> <p>Review of the facility policy titled, Grievances, last revised 06/2023, documented The Grievance Officer will coordinate actions with the appropriate state and federal agencies depending on the nature of the allegations. all alleged violations of neglect, abuse and or misappropriation of property will be reported and investigated under guidelines for reporting abuse and neglect, as per state law.</p> <p>Review of the facility policy titled, Abuse, Neglect, Exploitation, Misappropriation, Mistreatment and Injury of Unknown Origin (ANEMMI), last revised 10/2022 documented the following:</p> <p>Reporting and Response:</p> <p>All allegations of possible ANEMMI will be immediately reported to the abuse hotline by the Administrator or Designee and will be evaluated to determine the direction of the investigation</p> <p>Alleged violations are reported immediately, but not later than 2 hours after the allegation is made, if the vents that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>Review of a grievance dated 03/25/24 involving Resident #1 documented Patient reports aide is being mean and pulling on her arm multiple times, even after asking her not to .Aide is giving her a hard time about needing to be changed more (because her feeding tube). The document noted the grievance was resolved on 03/25/24.</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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident #1 conducted on 04/29/24 at 10:15 AM revealed an incident of abuse. The resident explained she initially reported the aide's actions to the therapists, she was so upset, she could not do her therapy and the staff recognized something was wrong and inquired about what was happening, she started to cry and the therapist helped her with writing the complaint. Resident #1 explained during care Staff A, a Certified Nursing Assistant, was mean to her, she kept pulling on her arms during care, despite her telling not to do so because it was painful. Resident #1 elaborated she had a stroke and her shoulders and arms are still stiff and painful.</p> <p>Interview with the Speech Therapist conducted on 04/30/24 at 12:05 PM revealed her recollection of the events; Resident #1 was not her usual self; she seemed down, and she inquired about what was happening. The Resident told her about her negative experience with the aide. She could not recall the details but stated she wrote a grievance and gave it to her boss and to the Administrator.</p> <p>Interview with the Director of Nursing conducted on 04/30/24 at 1:30 PM revealed the grievance was investigated by the Assistant Director of Nursing (ADON), who is currently out of the country. The DON stated the ADON spoke to the resident and the aide and provided the aide with education, it was addressed as a customer service concern at the time. The DON reviewed the file and confirmed the grievance was filed on 03/25/24 and the abuse allegation reporting was conducted on 03/27/24, after a state agency representative arrived at the facility to investigate the matter.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 29151</p> <p>Based on observation and interview, the facility failed to ensure a urinary catheter was secured to prevent excessive tension of the tubing; failed to provide catheter care following infection control practices to minimize complications; and failed to provide a privacy bag to promote the resident's privacy. The failure affected 1 of 2 sampled residents reviewed for urinary catheter care. (Resident #4)</p> <p>The findings included:</p> <p>Review of the facility policy titled, Catheter Care dated 01/2024 documented, The facility will maintain infection control guidelines related to catheter care use and catheter care to minimize catheter associated infections.</p> <p>Routine hygiene and care of the peri area is appropriate when providing incontinence care and bathing.</p> <p>Center of Disease Control (CDC) recommends maintenance and catheter care essentials:</p> <p>Use appropriate hand hygiene and gloves</p> <p>Properly secure catheters to prevent movement and urethral traction</p> <p>Maintain a sterile closed drainage system</p> <p>Maintain good hygiene at the catheter urethral interface</p> <p>Maintain unobstructed urine flow</p> <p>Maintain drainage bag below level of bladder at all times.</p> <p>Observation of care conducted on 04/30/24 starting at 7:55 AM revealed Staff A, a Certified Nursing Assistant, inside Resident #4's room that was identified as requiring contact precautions. It was noted the resident had an urinary catheter, half full with dark amber colored urine and visible from the hallway.</p> <p>Observation of care conducted on 04/30/24 at 8:12 AM, revealed Staff A, assisting Resident #4 with morning and catheter care. The aide had washcloths and a basin filled with water sitting on top of the bedside table. Staff A donned gloves and started to bathe the resident and noted dried blood stains around the left arm and bed sheets, about the size of a grapefruit, the aide uncovered the resident, there was a small skin injury to his left arm, then it was noted the Foley catheter was not secured and the tubing was pulling down above the resident's left leg.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Staff A then went to the door and called for a nurse to report the blood. Staff A continue with the bath, washed the resident's face and neck, rinsing the washcloth in the water. The Director of Nursing (DON) entered the room, checked on the resident's blood stain and told the aide to continue, and that she would care for the resident's arm.</p> <p>At this point, the DON was made aware by the surveyor that the resident's catheter tubing was pulling down and was and not secured and replied she will get an anchor. The aide continued the bath, washing the resident's chest, arms and then turning the resident on the side and washed his back and buttocks, It was noted the resident had a dressing to his coccyx, that was soiled and coming off the skin. The aide washed around the area, using washcloths and rinsing them in the water inside the basin. Then the aide proceeded to rinse another washcloth and turned the resident on his back and cleaned the Foley catheter tubing, from bottom to top and then washed the resident's genitals. The motion created pulling on the tubing and the resident moaned. Staff continued the care and was told to watch the catheter tubing twice during the observation as she was pulling on it during care and while repositioning the resident on her own. At this time the Unit Manager entered the room with a catheter tubing guard and proceeded to place the device, while applying the device, again the catheter tubing was pulling on the resident's insertion site and the staff was again told to watch out for the catheter.</p> <p>Upon interview with Staff A, during the observation of care, she confirmed that she used the same water to bathe the resident and provide catheter care.</p> <p>Clinical record review revealed Resident #4 was admitted to the facility on [DATE]. The Minimum Data Set admission assessment with reference date of 04/18/24 documented the resident was assessed as severely impaired for skills of daily decision making; has an urinary catheter and pressure wound.</p> <p>A Care plan dated 04/24/24 and titled, Resident presents with an indwelling catheter with potential for complications related to indwelling catheter documented the following interventions:</p> <p>Monitor, document, and notify physician of signs of complications related to catheter use including UTI, trauma and bleeding.</p> <p>Assess for urine characteristics (volume, color, clarity odor) and document; maintain closed drainage system, with drainage bag lower than bladder level at all times and keep drainage bag off floor and cover for dignity.</p>		