| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 106148 | A. Building<br>B. Wing | 10/03/2024 |

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

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on record review and interview, the facility failed to notify 1 of 8 sampled resident representatives of a change in condition and treatment (Resident #5).<br><br>The findings included:<br><br>Review of the record revealed Resident #5 was admitted to the facility on [DATE]. Review of the profile page revealed the specified family member of Resident #5 was the resident's first emergency contact. Review of the current Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 had a Brief Interview of Mental Status (BIMS) score of 6, on a 0 to 15, indicating the resident was cognitively impaired.<br><br>Further review of the record revealed a documented change in condition as of 09/09/24 of malaise (a vague feeling of discomfort) and poor appetite, with orders for laboratory work to include a urinalysis. The area on this change in condition form where the resident representative was to be notified was left blank. Review of the progress notes lacked any notification to the resident representative.<br><br>Review of the urinalysis results reported to the facility on [DATE] revealed Resident #5 had a Urinary Tract Infection (UTI) and the progress notes again lacked any notification to the resident representative.<br><br>During an interview on 10/03/24 in the afternoon, when made aware of the lack of notification to the resident representative of Resident #5's UTI, the Director of Nursing (DON) had no response. |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>25404<br><br>Based on policy review, observation, and interview, the facility failed to ensure a safe and functional environment as evidenced by the failure to maintain 4 of 6 Soiled Utility/Holding (biohazard) rooms secured (1E, 1W, 3E and 3W); failure to maintain 1 of 6 housekeeping areas secured (1W); failure to ensure 1 of 6 (2W) emergency exits of the residential areas secured; failure to ensure 2 of 2 observed oxygen tanks were secured; and failure to provide documented evidence of timely repairs for 4 of 4 resident toilets.<br><br>The findings included:<br><br>Review of the policy Oxygen Storage revised 12/2023 documented, General Guidelines: . 3. Oxygen Tanks should no be left free standing, as per facility protocol.<br><br>1) During a facility tour on 09/30/24 beginning at 10:47 PM, the following was observed with photographic evidence obtained:<br><br>a) At 11:00 PM the housekeeping door on 1W was propped open with a crushed water bottle. Inside the room was a mop bucket full of dark brown/black water and a gallon jar of cleaning solution labeled Danger Peligro.<br><br>b) At 11:14 PM the Soiled Utility/Holding door on 1E was propped open with the handle of a cleaning tool. Upon entering the room there were used gloves on the floor, a specimen refrigerator, and opened garbage container, and trash on the floor,<br><br>c) At 11:17 PM the fire exit door on 2W was ajar and not securely closed.<br><br>d) At 11:54 PM two containers of oxygen were noted on 2E, in the corridor on the north side of the nurse's station, that were not securely stored. The two tanks were on upright on the floor without any holder.<br><br>e) At 12:26 AM the Soiled Utility/Holding on 1W was noted with a broken keypad lock. Upon entering the room there were two open biohazard boxes, an open trash bin, four used gloves on the floor, an opened garbage bag on the floor, and a specimen refrigerator with what appeared to be an old unlabeled urine sample.<br><br>During an interview on 10/02/24 at 1:04 AM, when asked why or how long the Soiled Utility room on 1E had been propped open, Staff A, Registered Nurse (RN) was unsure and noted the broken keypad lock.<br><br>Observation on 10/01/24 beginning at 3:19 PM revealed the following with photographic evidence obtained:<br><br>f) The 1W Housekeeping door remained ajar utilizing the crushed water bottle.<br><br>g) The Soiled U/Holding door on 1W remained unlocked.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | h) The Soiled Utility/Holding door on 1E was no longer propped open but the door remained unlocked.<br><br>i) Upon arrival to the second floor at 3:50 PM, the fire door on 2W remained ajar.<br><br>j) Upon arrival to the third floor at 3:28 PM, the 3E Soiled Utility/Holding door was unlocked. An opened biohazard box and open trash container were noted.<br><br>k) The Soiled Utility/Holding door on 3W was unlocked with two opened biohazard boxes inside.<br><br>During an interview on 10/02/24 at 3:45 PM, the Director of Nursing (DON) was made aware of the observed concerns described above and with the photographs shared. The DON had no comments.<br><br>2) A confidential document documented a concern that a resident's toilet backed up on two occasions, with maintenance not responding for 24 hours for one of the occasions.<br><br>Review of the Work Orders report from 08/01/24 through 09/30/24 documented four orders related to broken toilets. This report lacked evidence of the actual reported and resolved/repaired dates.<br><br>During interview on 10/01/24 at 11:20 AM, 10/02/24 at 2:52 PM, and 10/03/24 at 5:30 PM, the Administrator was asked to provide the Work Order report with associated dates. This requested information was not provided. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on record review, incident review, and interview, the facility failed to ensure a complete and thorough investigation for 1 of 2 sampled residents with an allegation of neglect, as evidenced by a lack of written statements from all staff involved in the incident and contradictions during staff interviews regarding the incident with Resident #1 on 09/04/24.<br><br>The findings included:<br><br>Review of the record revealed Resident #1 was admitted to the facility on [DATE] and transferred out to the hospital on 09/04/24, after dislodgement of the resident's Peripherally Inserted Central Catheter (PICC/intravenous access through a vein in the arm and threaded into a large vein near the heart). A change in condition form and progress note, both dated 09/04/24 at 7:15 PM but created eight days after the event on 09/12/24 by the Assistant Director of Nursing (ADON), simply documented the PICC line was noted on the floor with a small quantity of blood on the floor, sheets and adjacent to the IV site on the resident's right arm.<br><br>On 09/09/24 at 2:29 PM a State Agency representative arrived at the facility and reported an allegation of inadequate supervision of Resident #1, after having accidentally pulling out her IV line. The subsequent confidential report documented the allegation included her clothing was soiled with blood, and that the nurse, Staff B, Registered Nurse (RN), began cleaning up the room and left without changing her. This report further documented the nurse stated he had moved the gown enough to clean the affected area and stop the bleeding, and that when paramedics arrived the nurse stepped away. Further review of the record lacked any type of progress note by Staff B, RN, regarding the incident for Resident #1. Review of the investigation revealed the thorough investigation completed by the facility only included interviews with Staff B, RN who assisted Resident #1, Staff C, RN who was the day shift nurse for Resident #1, who left early after giving report to Staff B, and Staff D, Certified Nursing Assistant (CNA), who was requested by Staff B, RN, to assist with Resident #1 during the incident.<br><br>The investigation lacked interviews with additional staff, including the day shift CNA assigned to Resident #1, or any of the night shift nurses or aides who were arriving at the time of the incident, to determine an accurate description and timeline of the event. Without a thorough investigation the facility would be unable to determine if neglect or any other concerns were present at the time of the event that would have needed to be addressed.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/02/24 at 3:59 PM, Staff B, RN, confirmed he worked the 12-hour day shift. When asked what happened on 09/04/24 with Resident #1's PICC, the RN explained he was by himself as the other nurse for the day had left early. Staff B explained the other nurse had given report to him, explaining she had hung an IV antibiotic, and Resident #1's PICC would need to be flushed. Staff B stated he went to flush the IV and a CNA stated there was an emergency as she had pulled the IV out. The RN stated he had two CNAs help clean her up and emergency personnel arrived. The RN stated he asked why they were there, and the emergency personnel stated the family had called them. The RN stated by the time the emergency personnel came, he had finished and was trying to get a gown, when the emergency personnel told him to get out. Staff B stated the resident was fine, and the resident was left with the CNAs and the paramedics. Staff B would not describe the blood but just kept saying she was fine when 911 came to the room. The RN did say there was some blood on her personal clothing (top) and so they had to get a hospital gown. When asked why he did not write a progress note about the incident, Staff B, RN stated it was shift change and Resident #1 was not on his assignment, so he didn't write anything.<br><br>The written statement by Staff B, RN, for the investigation documented a CNA informed him the IV pump was beeping and upon arrival into the room the IV line was out. This statement documented there was some blood, the resident was in her personal gown, and he asked CNA staff to clean her up. This statement documented that clean gowns were already in the room. This statement documented police came in, harassed him, and accused him of not showing up on time.<br><br>During an interview on 10/02/24 at 2:29 PM, Staff E, CNA assigned to Resident #1 on 09/04/24, explained she works the day shift from 7 AM to 7:30 PM. When asked about the incident with Resident #1's PICC line, the CNA stated she had checked on the resident during her last rounds between 6:30 PM and 6:45 PM, and the resident was fine. The CNA stated she heard about the incident but did not see anything, stating she thought it happened after shift change. Review of the PPD Detail Report (report generated for clocking in and out, documented Staff E, CNA, clocked out at 7:30 PM.<br><br>The investigation lacked any written statement from Staff E, CNA assigned to Resident #1 during the day shift on 09/04/24.<br><br>During an interview on 10/02/24 at 2:43 PM, Staff D, CNA who was asked to assist by Staff B, covering RN, explained Resident #1 was not on her assignment, but it was change of shift and Staff B, covering RN, grabbed her to assist. The CNA stated upon arrival to the room, Resident #1 was hysterical. There was blood. We were there just two minutes, and the door flew open, and the paramedics took over. When asked how much blood, Staff D stated she was told not to describe it as drenched, and would not quantify, but stated there was blood all over the resident's clothes and the bed. The CNA again stated she and Staff B, covering RN, were only in the room about two minutes before the emergency personnel arrived.<br><br>Review of the written statement from Staff D, CNA revealed she and Staff B, RN went to the room, and the RN tried to stop the bleeding and get rid of the soiled clothes and linen, while she had clean linens. This statement stated the emergency personnel arrived, Staff B tried to explain what happened, and the emergency personnel told him to leave.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a phone interview on 10/02/24 at 5:34 PM, Staff F, CNA explained she worked the night shift from 7 PM to 7:30 AM. When asked about the incident on 09/04/24 with Resident #1's PICC line, the CNA explained she had clocked in downstairs a little before 7 PM and took the back elevator to the second floor. Review of the PPD Detail Report documented Staff F clocked in at 6:42 PM. The CNA stated as soon as the elevator doors opened on the second floor, she heard screaming. The CNA stated she dropped her stuff at the nurse's station, and ran into the room of Resident #1, and her gown was drenched in blood. The CNA stated she went to try and find her day nurse, she could not find her, so she went to the back side of the unit and found Staff B, RN and told him Resident #1 was bleeding and it was a lot. When asked if the resident was in bed, the CNA stated she was and that there was a lot of blood there as well. Staff F, CNA, stated that a day shift CNA finally came and said she (the resident) had been like that for about an hour. When asked which day shift CNA she was speaking about, Staff F, CNA described Staff D, CNA. When asked again about what time she arrived on the second floor, Staff F again stated, just a little before 7 PM.<br><br>During an interview on 10/03/24 at 4:00 PM, when asked if she was in the building when the PICC line for Resident #1 came out, the ADON stated she was not, but was nearby and returned to the facility. When asked what she observed, the ADON stated the resident was gone by the time she returned. When asked why she entered the note about the event, the ADON stated she was assisting Staff B, covering RN, and asking him what happened so she would initiate a report. When asked why she documented a small amount of blood in the progress note, the ADON stated because that is what she saw after the incident. When asked what Staff B told her, the ADON stated Staff B said he received report from the other nurse and that there was an antibiotic running that would need to be checked. He stated he was notified by a CNA on the other side of the unit that the machine was beeping. When he went into the room, he saw the line on the floor and blood on the bed, floor, and gown. The RN verbalized the resident was irate. The RN told the ADON he had asked the CNA to apply a new gown and change the linens, and that the paramedics arrived while the CNA went to get a gown, and they took over. When asked if any of the other day shift staff who worked the second floor, or if any of the night shift staff were interviewed since the even happened at or near shift change, the ADON stated not to her knowledge. The ADON did state that Staff D, CNA told her via phone that the resident was drenched with blood . blood was all over. The ADON stated she asked her how she could be drenched with blood and the CNA stated there was a lot of blood. The ADON stated at the end of the phone conversation, she asked Staff D to email her a statement.<br><br>During a phone interview on 10/03/24 at 9:50 AM, the family member of Resident #1 explained he had just left the faciity on [DATE], and was still driving, when he received a call from [Resident #1]. The family member stated she was hysterical about her IV coming out, there was blood everywhere, and staff were not answering the call bell, so he called 911. When asked what time he called 911, the family member looked at his cell phone history and stated at 6:50 PM. |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on record review and interview the facility failed to ensure daily wound care for 1 of 4 sampled residents with surgical incisions (Resident #2). The lack of daily wound care for Resident #2 resulted in maceration of the surgical skin flap resulting in exposure to the bone with need for additional surgery; and the facility failed to ensure appropriate care and services for 1 of 2 sampled residents with an IV (intravenous) line (Resident #1). The lack of timely response to needed care for a Peripherally Inserted Central Catheter (PICC) line dislodgement for Resident #1 on 09/04/24 resulted in psychological harm as evidenced by staff and family report that the resident was irate and hysterical.<br><br>The findings included:<br><br>1. Review of the record revealed Resident #2 was admitted to the facility on [DATE] and send to the hospital directly from a surgical post-operative office visit on 09/03/24.<br><br>Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 12, on a 0 to 15 scale, indicating the resident was cognitively intact. This same MDS documented the resident had a surgical wound.<br><br>Review of the hospital record revealed the surgeon placed Negative Pressure Wound Therapy (NPWT) to Resident #2's surgical wound on 08/21/24, and it was discontinued at the hospital on 08/26/24 prior to admission to the facility. The Wound Care Consult from the hospital documented the right foot wound care as to clean with normal saline, pat dry well, and cover.<br><br>Review of the physician order dated 08/26/24, upon arrival to the facility, instructed staff to clean the right foot surgical wound with normal saline, pat dry, apply a non-adherent dressing, and secure daily. A second wound care order dated 08/29/24, written by the facility's wound care nurse and signed off by the facility's rehab physician, documented staff were to cleanse the right toe surgical wound daily with Vashe Wound Therapy External Solution (wound cleanser), pat dry, apply collagen to site, cover with a silicone foam dressing daily. This order also documented to protect the peri wound with skin prep and included a PRN order every 8 hours as needed.<br><br>Review of the Treatment Administration Records (TARs) revealed wound care was not provided to Resident #2 on 08/09/24 and 08/31/24 as evidenced by a lack of nurse signature on those two dates. Review of the associated progress notes lacked any reason for the lack of care. Further review of the progress notes and scanned documents lacked any communication or order from the surgeon related to the change in wound care orders.<br><br>During a phone interview on 09/26/24 at 1:10 PM, the adult daughter of Resident #2, who is also a physician, explained that during the resident's surgical follow-up office visit on 09/03/24, her father (Resident #2) told the surgeon the wound care had not been provided daily. Upon observation of the surgical site by the surgeon, he stated the lack of wound care macerated the skin flap, resulting in the skin flap not working and additional damage to the toe, resulting in the need for hospitalization and further surgery.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 10/03/24 at 3:43 PM, when asked why the wound care order for Resident #2 was changed and not completed as ordered, the First Floor Unit Manager did not know and was unable to find rationale in the record. The Unit Manager confirmed the order change was written by the facility's wound care nurse and further explained she does rounds with a wound care provider. During a side-by-side review of the record the Unit Manager was unable to locate any notes from the wound care provider.<br><br>During a phone interview on 10/03/24 at 5:04 PM, when asked why the wound care order was changed, the facility's wound care nurse stated she had called the surgeon to schedule the follow-up appointment for Resident #2, and while on the phone she was given the verbal order for the change. The wound care nurse stated she thought that the new order was what the surgeon wanted. When asked if there was any documentation of this, the wound care nurse stated they had faxed over the order. The faxed order was never located or provided.<br><br>2. Review of the record revealed Resident #1 was admitted to the facility on [DATE] and transferred out the the hospital on 09/04/24, after dislodgement of the resident's Peripherally Inserted Central Catheter (PICC/intravenous access through a vein in the arm and threaded into a large vein near the heart). Review of the Medication Administration Record (MAR) revealed the IV antibiotic Invance 1 gram was started at 5:33 PM by Staff C, RN, who was the assigned direct care nurse for Resident #1 on 09/04/24 during the day shift. Review of the PPD Detail Report (a report generated for staff clocking in and out) revealed Staff C had clocked out at 6:24 PM on 09/04/24.<br><br>A change in condition form and progress note, both dated 09/04/24 at 7:15 PM but created eight days after the event on 09/12/24 by the Assistant Director of Nursing (ADON), simply documented the PICC line was noted on the floor with a small quantity of blood on the floor, sheets and adjacent to the IV site on the resident's right arm.<br><br>During an interview on 10/02/24 at 3:59 PM, Staff B, RN, confirmed he worked the 12 hour day shift. When asked what happened on 09/04/24 with Resident #1's PICC line, the RN explained he was by himself as the other nurse for the day had left early. Staff B explained the other nurse had given report to him, explaining she had hung an IV antibiotic, and Resident #1's PICC would need to be flushed. Staff B stated he went to flush the IV and a CNA stated there was an emergency as she had pulled the IV out. The RN stated he had two CNAs help clean the resident up and emergency personnel arrived. The RN stated he asked why they were there, and the emergency personnel stated the family had called them. The RN stated by the time the emergency personnel came, he had finished and was trying to get a gown, when the emergency personnel told him to get out. Staff B stated the resident was fine, and the resident was left with the CNAs and the paramedics. Staff B would not describe the blood but just kept saying she was fine when 911 came to the room. The RN did say there was some blood on her personal clothing (top) and so they had to get a hospital gown. When asked why he did not write a progress note about the incident, Staff B, RN stated it was shift change and Resident #1 was not on his assignment, so he didn't write anything.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 10/02/24 at 2:29 PM, Staff E, CNA assigned to Resident #1 on 09/04/24, explained she works the day shift from 7 AM to 7:30 PM. When asked about the incident with Resident #1's PICC line, the CNA stated she had checked on the resident during her last rounds between 6:30 PM and 6:45 PM, and the resident was fine. The CNA stated she heard about the incident but did not see anything, stating she thought it happened after shift change. Review of the PPD Detail Report ( documented Staff E, CNA, clocked out at 7:30 PM. (Note as documented below, the family member stated [Resident #1] phoned him at 6:50 PM and was hysterical about the PICC line being out, thus the event happened before Staff E clocked out.)<br><br>During an interview on 10/02/24 at 2:43 PM, Staff D, CNA who was asked to assist by Staff B, covering RN, explained Resident #1 was not on her assignment, but it was change of shift and Staff B, covering RN, grabbed her to assist. The CNA stated upon arrival to the room, Resident #1 was hysterical. There was blood. We were there just two minutes and the door flew open, and the paramedics took over. When asked how much blood, Staff D stated she was told not to describe it as drenched, and would not quantify, but stated there was blood all over the resident's clothes and the bed. The CNA again stated she and Staff B, covering RN, were only in the room about two minutes before the emergency personnel arrived. As per a phone interview on 09/26/24 at 2:23 PM with law enforcement, paramedics and law enforcement were on the premises at 7:10 PM.<br><br>During a phone interview on 10/02/24 at 5:34 PM, Staff F, CNA explained she worked the night shift from 7 PM to 7:30 AM. When asked about the incident on 09/04/24 with Resident #1's PICC line, the CNA explained she had clocked in downstairs a little before 7 PM, and took the back elevator to the second floor. Review of the PPD Detail Report documented Staff F clocked in at 6:42 PM. The CNA stated as soon as the elevator doors opened on the second floor, she heard screaming. The CNA stated she dropped her stuff at the nurse's station, and ran into the room of Resident #1, and her gown was drenched in blood. The CNA stated she went to try and find her day nurse, could not find her, so she went to the back side of the unit and found Staff B, RN and told him Resident #1 was bleeding and it was a lot. When asked if the resident was in bed, the CNA stated she was and that there was a lot of blood there as well. Staff F, CNA, stated that a day shift CNA finally came and said she (the resident) had been like that for about an hour. When asked which day shift CNA she was speaking about, Staff F, CNA described Staff D, CNA. When asked again about what time she arrived on the second floor, Staff F again stated, just a little before 7 PM.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 106148 | A. Building<br>B. Wing | 10/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Luxe at Jupiter Rehabilitation Center (the) | 674 Pioneer Road<br>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.

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|---|---|
| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 10/03/24 at 4:00 PM, when asked if she was in the building when the PICC line for Resident #1 came out, the ADON stated she was not, but was nearby and returned to the facility. When asked what she observed, the ADON stated the resident was gone by the time she returned. When asked why she entered the note about the event, the ADON stated she was assisting Staff B, covering RN, and asking him what happened so she would initiate a report. When asked why she documented a small amount of blood in the progress note, the ADON stated because that is what she saw after the incident. When asked what Staff B told her, the ADON stated Staff B said he received report from the other nurse and that there was an antibiotic running that would need to be checked. He stated he was notified by a CNA on the other side of the unit that the machine was beeping. When he went into the room, he saw the line on the floor and blood on the bed, floor, and gown. The RN verbalized the resident was irate. The RN told the ADON he had asked the CNA to apply a new gown and change the linens, and that the paramedics arrived while the CNA went to get a gown, and they took over. When asked if any of the other day shift staff who worked the second floor, or if any of the night shift staff were interviewed since the event happened at or near shift change, the ADON stated not to her knowledge. The ADON did state that Staff D, CNA told her via phone that the resident was drenched with blood . blood was all over. The ADON stated she asked her how she could be drenched with blood and the CNA stated there was a lot of blood. The ADON stated at the end of the phone conversation, she asked Staff D to email her a statement.<br><br>During a phone interview on 10/03/24 at 9:50 AM, the family member of Resident #1 explained he had just left the faciity on [DATE], and was still driving, when he received a call from [Resident #1]. The adult family member stated she was hysterical about her IV coming out, there was blood everywhere, and staff were not answering the call bell, so he called 911. When asked what time he called 911, the family member looked at his cell phone history and stated at 6:50 PM. |

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|---|---|
| F 0694<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on record review and interview, the facility failed to ensure appropriate care and services for 1 of 2 sampled residents with an IV (intravenous) line (Resident #1). The lack of timely response to needed care for a Peripherally Inserted Central Catheter (PICC) line dislodgement for Resident #1 on 09/04/24 resulted in psychological harm as evidenced by staff and family report that the resident was irate and hysterical.<br><br>The findings included:<br><br>Review of the record revealed Resident #1 was admitted to the facility on [DATE] and transferred out the the hospital on 09/04/24, after dislodgement of the resident's Peripherally Inserted Central Catheter (PICC/intravenous access through a vein in the arm and threaded into a large vein near the heart). Review of the Medication Administration Record (MAR) revealed the IV antibiotic Invance 1 gram was started at 5:33 PM by Staff C, RN, who was the assigned direct care nurse for Resident #1 on 09/04/24 during the day shift. Review of the PPD Detail Report (a report generated for staff clocking in and out) revealed Staff C had clocked out at 6:24 PM on 09/04/24.<br><br>A change in condition form and progress note, both dated 09/04/24 at 7:15 PM but created eight days after the event on 09/12/24 by the Assistant Director of Nursing (ADON), simply documented the PICC line was noted on the floor with a small quantity of blood on the floor, sheets and adjacent to the IV site on the resident's right arm.<br><br>During an interview on 10/02/24 at 3:59 PM, Staff B, RN, confirmed he worked the 12 hour day shift. When asked what happened on 09/04/24 with Resident #1's PICC line, the RN explained he was by himself as the other nurse for the day had left early. Staff B explained the other nurse had given report to him, explaining she had hung an IV antibiotic, and Resident #1's PICC would need to be flushed. Staff B stated he went to flush the IV and a CNA stated there was an emergency as she had pulled the IV out. The RN stated he had two CNAs help clean the resident up and emergency personnel arrived. The RN stated he asked why they were there, and the emergency personnel stated the family had called them. The RN stated by the time the emergency personnel came, he had finished and was trying to get a gown, when the emergency personnel told him to get out. Staff B stated the resident was fine, and the resident was left with the CNAs and the paramedics. Staff B would not describe the blood but just kept saying she was fine when 911 came to the room. The RN did say there was some blood on her personal clothing (top) and so they had to get a hospital gown. When asked why he did not write a progress note about the incident, Staff B, RN stated it was shift change and Resident #1 was not on his assignment, so he didn't write anything.<br><br>During an interview on 10/02/24 at 2:29 PM, Staff E, CNA assigned to Resident #1 on 09/04/24, explained she works the day shift from 7 AM to 7:30 PM. When asked about the incident with Resident #1's PICC line, the CNA stated she had checked on the resident during her last rounds between 6:30 PM and 6:45 PM, and the resident was fine. The CNA stated she heard about the incident but did not see anything, stating she thought it happened after shift change. Review of the PPD Detail Report documented Staff E, CNA, clocked out at 7:30 PM. (Note as documented below, the family member stated [Resident #1] phoned him at 6:50 PM and was hysterical (about the PICC line being out) thus the event happened before Staff E clocked out).<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 10/02/24 at 2:43 PM, Staff D, CNA who was asked to assist by Staff B, covering RN, explained Resident #1 was not on her assignment, but it was change of shift and Staff B, covering RN, grabbed her to assist. The CNA stated upon arrival to the room, Resident #1 was hysterical. There was blood. We were there just two minutes and the door flew open, and the paramedics took over. When asked how much blood, Staff D stated she was told not to describe it as drenched, and would not quantify, but stated there was blood all over the resident's clothes and the bed. The CNA again stated she and Staff B, covering RN, were only in the room about two minutes before the emergency personnel arrived. As per a phone interview on 09/26/24 at 2:23 PM with law enforcement, paramedics and law enforcement were on the premises at 7:10 PM.<br><br>During a phone interview on 10/02/24 at 5:34 PM, Staff F, CNA explained she worked the night shift from 7 PM to 7:30 AM. When asked about the incident on 09/04/24 with Resident #1's PICC line, the CNA explained she had clocked in downstairs a little before 7 PM, and took the back elevator to the second floor. Review of the PPD Detail Report documented Staff F clocked in at 6:42 PM. The CNA stated as soon as the elevator doors opened on the second floor, she heard screaming. The CNA stated she dropped her stuff at the nurse's station, and ran into the room of Resident #1, and her gown was drenched in blood. The CNA stated she went to try and find her day nurse, could not find her, so she went to the back side of the unit and found Staff B, RN and told him Resident #1 was bleeding and it was a lot. When asked if the resident was in bed, the CNA stated she was and that there was a lot of blood there as well. Staff F, CNA, stated that a day shift CNA finally came and said she (the resident) had been like that for about an hour. When asked which day shift CNA she was speaking about, Staff F, CNA described Staff D, CNA. When asked again about what time she arrived on the second floor, Staff F again stated, just a little before 7 PM.<br><br>During an interview on 10/03/24 at 4:00 PM, when asked if she was in the building when the PICC line for Resident #1 came out, the ADON stated she was not, but was nearby and returned to the facility. When asked what she observed, the ADON stated the resident was gone by the time she returned. When asked why she entered the note about the event, the ADON stated she was assisting Staff B, covering RN, and asking him what happened so she would initiate a report. When asked why she documented a small amount of blood in the progress note, the ADON stated because that is what she saw after the incident. When asked what Staff B told her, the ADON stated Staff B said he received report from the other nurse and that there was an antibiotic running that would need to be checked. He stated he was notified by a CNA on the other side of the unit that the machine was beeping. When he went into the room, he saw the line on the floor and blood on the bed, floor, and gown. The RN verbalized the resident was irate. The RN told the ADON he had asked the CNA to apply a new gown and change the linens, and that the paramedics arrived while the CNA went to get a gown, and they took over. When asked if any of the other day shift staff who worked the second floor, or if any of the night shift staff were interviewed since the event happened at or near shift change, the ADON stated not to her knowledge. The ADON did state that Staff D, CNA told her via phone that the resident was drenched with blood . blood was all over. The ADON stated she asked her how she could be drenched with blood and the CNA stated there was a lot of blood. The ADON stated at the end of the phone conversation, she asked Staff D to email her a statement.<br><br>During a phone interview on 10/03/24 at 9:50 AM, the family member of Resident #1 explained he had just left the faciity on [DATE], and was still driving, when he received a call from his [Resident #1]. The family member stated she was hysterical about her IV coming out, there was blood everywhere, and staff were not answering the call bell, so he called 911. When asked what time he called 911, the family member looked at his cell phone history and stated at 6:50 PM. |

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| Luxe at Jupiter Rehabilitation Center (the) | 674 Pioneer Road<br>Jupiter, FL 33458 |

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|---|---|
| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on record review, incident review, and interview, the facility failed to ensure sufficient staffing, as evidenced by the lack of timely response to needed PICC (Peripherally Inserted Central Catheter) line dislodgment care for 1 of 2 sampled residents with an IV (intravenous) line (Resident #1); and as evidenced by numerous verbal and written complaints.<br><br>The findings included:<br><br>1) Review of the record revealed Resident #1 was admitted to the facility on [DATE] and transferred out the hospital on 09/04/24, after dislodgement of the resident's Peripherally Inserted Central Catheter (PICC/intravenous access through a vein in the arm and threaded into a large vein near the heart). Review of the Medication Administration Record (MAR) revealed the IV antibiotic Invance 1 gram was started at 5:33 PM by Staff C, RN, who was the assigned direct care nurse for Resident #1 on 09/04/24 during the day shift. Review of the PPD Detail Report, that documented when staff clock in and out, revealed Staff C had clocked out at 6:24 PM.<br><br>Record review and interviews with staff and Resident #1's family member revealed sometime between 6:30 PM and 6:45 PM on 09/04/24, the PICC line for Resident #1 came out, resulting in the resident's gown drenched in blood with the resident becoming irate and hysterical. Resident #1 phoned her family member at 6:50 PM as no staff were answering the call bell, and the family member phoned 911. A few minutes before 7 PM, a night Certified Nursing Assistant (CNA) heard screaming as she exited the elevator on the second floor and was unable to find the resident's Direct Care Nurse and had to search for the second nurse assigned to that floor. Staff finally attended to Resident #1 at approximately 7:05 PM. (Refer to F694 for details).<br><br>Review of the census, staffing information, and time sheets revealed the number of residents on the second floor was 26 or 27, depending upon the time related to admissions and discharges. The nurse staffing for the second floor consisted of Staff B, Registered Nurse (RN) who worked from 7:26 AM until 7:44 PM, Staff C, RN assigned to Resident #1, who worked from 8:04 AM to 6:24 PM, as a favor to the staffing coordinator. The CNA staffing for the second floor consisted of Staff E, CNA assigned to Resident #1, who worked from 6:59 AM until 7:30 PM, and Staff D, CNA, who worked from 7:00 AM until 7:28 PM. The third scheduled CNA was a no call/no show as per the staffing coordinator during an interview on 10/03/24 at 4:28 PM.<br><br>2) Confidential complaints about a lack of staffing and/or staff response on 05/07/24, 06/27/24, 07/01/24, 08/06/24, 08/20/24, 08/28/24 and 09/26/24, revealed the following:<br><br>a) An anonymous written complaint dated 08/07/24, documented upon visiting the facility on 08/06/24, a resident was pressing the call button and screaming in pain for help. Upon arrival family members were trying to get help and the nurse was telling the family she had a bunch of other residents that she was taking care of. This written complaint documented the facility appears to be short staffed and that the resident who was visited stated he had seen night staff sleeping while on duty.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b) A written complaint dated 08/20/24 from a confidential family member documented he had found [Resident] sitting in urine and had observed long call light response times. This complaint also documented a lack of night staff availability with photos of a nurse sleeping at the nurse's station.<br><br>c) Another State Agency reported there have been multiple confirmed and unresolved complaints related to slow call bell response and lack of care dated from 05/07/24, with the two most recent complaints and verified findings on 06/27/24, 07/01/24 and 08/28/24.<br><br>d) A confidential report on 09/26/24 at 2:23 PM revealed night patrol officers have a difficult time getting a response to all entrances into the building after the front desk receptionist goes home. Staff members have also been observed sleeping at the nurse's stations with their heads on a pillow.<br><br>e) During a confidential interview on 10/01/24 at 12:40 AM, when asked if she had knowledge of staff sleeping during their night shift, the individual stated, Yes, especially on Wednesdays on the first floor. I've seen staff sleeping sitting up in the Activity Room, or in the sitting area between the two units. Some of them even have blankets and pillows. Another individual was present and agreed. Neither of the individuals would provide names of specific sleeping staff. When asked if they covered the call bells for the sleeping staff, both stated, No, I would go wake them up. At 12:50 AM another individual joined the conversation. The individual would not confirm directly if she knew of staff sleeping, but when asked if she would cover for a sleeping staff member, she stated, No, I'd go wake them up.<br><br>f) During a confidential phone interview on 10/02/24 at 5:27 PM, when asked about staffing on the night shift, the individual stated this week was the first time she had consistently seen three aides on the floor. The individual stated often there are only two.<br><br>g) During a confidential phone interview on 10/03/24 at 9:50 AM, it was reported All in all they are understaffed. They have one nurse on the floor and the rest are aides. There is a no urgency feeling from the staff or a lack of need to get to the resident shown by the staff. They also show the attitude of I'm not here to help you, but you are to do what I tell you. One nurse is not sufficient, especially if there is an emergency. |

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|---|---|
| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on record review and interview the facility failed to ensure food preferences for 2 of 3 sampled residents (Residents #7 and #8).<br><br>The findings included:<br><br>1) Review of the record revealed Resident #7 was admitted to the facility on [DATE]. During an interview on 10/02/24 at 11:09 AM, the resident stated some of the food is just about inedible and unable to recognize. When asked if she could get an alternate meal upon request, the resident stated, I eat the PB&J (peanut butter and jelly) and tuna sandwiches, but they haven't had any tuna now for the past couple of weeks. When asked how she knows what is on the menu for that day, Resident #7 stated I have to look at the menu on the wall.<br><br>During an observation and interview on 10/02/24 at about 2:00 PM, when asked if there has been an issue providing tuna sandwiches over the past two weeks, the Kitchen Manager stated he had plenty of tuna and showed the surveyor a partial case of restaurant sized can tuna. When told Resident #7 was informed by direct care staff that they have been out of tuna for a couple of weeks, the Kitchen Manager stated he was not getting any requests for the tuna sandwiches. The Kitchen Manager was asked to provide the menu ticket for Resident #7. Upon provision of the menu ticket for Resident #7, it lacked any preferences. When asked who was responsible for obtaining a new resident's preferences, the Kitchen Manager stated he was and had not spoken to Resident #7 to obtain any preferences.<br><br>2) Review of the record revealed Resident #8 was admitted to the facility on [DATE].<br><br>During an observation and interview on 10/02/24 at 12:09 PM, Resident #8 had only eaten a few bites of lunch. When asked if she like it, the resident shook her head no and just pushed it away and stated, Thank goodness I'm not here to eat and gain weight. When asked if she could get any alternate meal, the resident stated she did get a grilled cheese sandwich last night because whatever they served was something I could not identify.<br><br>During a supplemental interview on 10/03/24 at 12:45 PM, Resident #8 again stated she does not like the food. When told there were alternates available, the resident stated, That's what everyone says but no one has provided any menu or options. They keep telling me I should get a packet with the information, but I've not received anything.<br><br>During an interview on 10/03/24 at 2:53 PM, the Kitchen Manager explained that upon admission the concierge should provide a new resident with the menu cycle and always available items. At 2:58 PM, the Kitchen Manager accompanied the surveyor to the room of Resident #8. Before entering the room, the Kitchen Manager stated he had spoken with the resident that morning. When asked what was said, the Kitchen Manager stated she told him her life story and that she hated the food. What can I do? When asked if he provided a menu and or alternates, the Kitchen Manager stated he had not and that she did not request one. Upon entering the room, when asked if she was provided the menu and alternate menu, Resident #8 stated, Yea, my family member picked it up this morning. |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on policy review, observation, and interview, the facility failed to maintain an infection control program as evidenced by the failure to initiate and maintain Enhanced Barrier Precautions (EBP) for 4 of 4 sampled residents (Resident #1, #6, #7 and #8)<br><br>The findings included:<br><br>Review of the policy titled,Enhanced Barrier Precautions, revised 05/28/24 documented, Procedure: 1. Enhanced Barrier Precautions (EBP) are used for resident with any of the following: . b. Wounds and/or indwelling medical devices even if the resident is not known to be colonized with MDRO (multidrug-resistant organisms). 9. Appropriate PPE for EBP would include: a. Gown. b. Gloves. 10. Employees should wear appropriate PPE when performing the following duties for residents requiring EBP:<br><br>a. Dressing<br><br>b. Bathing/Showering<br><br>c. Transferring<br><br>d. Providing hygiene<br><br>e. Changing soiled linens<br><br>f. Providing pericare such as changing briefs<br><br>g. Toileting<br><br>h. Device care<br><br>i. Wound care<br><br>1) Review of the record revealed Resident #1 was admitted to the facility on [DATE] for the provision of wound care and IV (intravenous) antibiotics via a Peripherally Inserted Central Catheter (PICC/intravenous access through a vein in the arm and threaded into a large vein near the heart).<br><br>Review of physician orders, Medication and Treatment Administration Orders (MARs and TARs), and progress notes lacked any documented evidence of the use of EBP for Resident #1.<br><br>2) Review of the record revealed Resident #6 was admitted to the facility on [DATE] for the provision of wound care, after having a right above the knee amputation.<br><br>During an observation on 10/03/24 at 10:37 AM, when asked why she was at the facility, Resident #6 lifted her blanket and a dressing to her right leg surgical area was noted. An observation of the door lacked any sign to indicate the resident was on EBP (Photographic Evidence Obtained).<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3) Review of the record revealed Resident #7 was admitted to the facility on [DATE] for the provision of IV antibiotics.<br><br>During an observation and interview on 10/02/24 at 11:09 AM, an IV antibiotic was noted infusing. When asked if staff wear any type of gown while caring for her, while assisting with her bath, while doing the IV dressing change, etc. Resident #7 stated, No, they just wear their uniform and gloves. An observation of the door lacked any sign to indicate the resident was on EBP (Photographic Evidence Obtained).<br><br>4) Review of the record revealed Resident #8 was admitted to the facility on [DATE] with a fresh right knee surgical wound. Observation of the door lacked any sign to indicate the resident was on EBP (Photographic Evidence Obtained).<br><br>During an interview on 10/02/24 at 3:48 PM, Staff K, Certified Nursing Assistant (CNA), was able to verbalize what EBP was and when to use the gown for protection. when asked how she would know if a resident was on EBP, the CNA stated there would be a sign on the door. |