| 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 | 11/24/2025 |

| 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.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain dignity for 1 of 3 sampled residents, as evidenced by sending Resident #2, who was severely cognitively impaired, to a physician's appointment wearing two hospital gowns. He was left unattended for 45 minutes in the main waiting area of the physician's office, where 42 people entered during that time.The findings included:Review of the record revealed Resident #2 was admitted to the facility on [DATE] with a diagnosis of cognitive communication deficit. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 3, on a 0 to 15 scale, indicating severe cognitive impairment. This same MDS also documented the resident had bilateral lower extremity impairment, needed the total assistance from staff for transfers, toileting, and lower body needs, while needing substantial to maximum assistance from staff for upper body needs.During a phone interview on 10/22/25 at 10:33 AM, the cardiology office Practice Manager explained that Resident #2 had a new patient cardiology appointment scheduled for 10/03/25. The Practice Manager explained that when an appointment was made with a resident who resides in a facility, especially a cognitively impaired resident, their office staff explains that the resident must be accompanied by facility staff or a family member to assist with the resident. The Practice Manager explained Resident #2 was dropped off by a driver, who handed the receptionist paperwork, and started to leave. The driver was asked if anyone was accompanying the resident, and the driver stated he was just told to drop off the resident and left. The Practice Manager explained their receptionist was unable to reach anyone at the facility, and further explained she herself had called multiple times, speaking with the receptionist of the facility, who had no knowledge of the appointment, and that she was put through to staff on numerous calls but was never able to speak with any nursing staff. The Practice Manager stated she left messages requesting the facility to call back, which never happened. The Practice Manager explained that their office staff also reached out to the three family members listed on the resident's face sheet but did not get a response until after the resident left. A voice message was left by a family member of Resident #2, who apologized and stated she was unaware of the appointment.During the continued phone interview on 10/22/25 at 10:33 AM, when asked to describe what she saw with Resident #2, the Practice Manager stated she saved the video of the main waiting area for that date and pulled it up while on the phone. The Practice Manager described Resident #2 arriving at the cardiologist's office, wearing two hospital gowns and hospital socks, sitting in a wheelchair. The Practice Manager stated the resident was wearing oxygen and was constantly playing with his gown, exposing his adult brief. She noted the tubing of an indwelling urinary catheter as well. The Practice Manager stated her staff provided him with a paper cover, used for patients during diagnostic testing, but the resident crumpled it up and offered it to another resident in the waiting area. The Practice Manager stated the office thermostat was maintained at 72 degrees F.Review of the 45-minute-long video of the main waiting area, provided by the cardiology office, revealed the following: Resident #2 was wheeled into the office and placed in front of the receptionist's window. The man who pushed him into the office, dropped off<br>(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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | some papers, started to leave when he was apparently called back, motioned that he dropped off the resident, and left. There were five other patients in the waiting room at that time. Resident #2 was wearing two short-sleeved hospital gowns and hospital type socks. Resident #2 was left in front of the receptionist's window in his wheelchair for a couple of minutes. When two additional patients arrived to check in, an office staff member moved the resident out of the way of the receptionist's window and placed him near the chairs located near the entrance door. Resident #2 was observed continuously manipulating his hospital gown exposing his legs and adult brief. At approximately 5 minutes into the video, office staff provided a paper-type cover, spread it out, and covered the lap of Resident #2. The resident immediately crumbled it up and offered it to another patient sitting next to him. Throughout the 45-minute video, Resident #2 continued to play with his gown and the crumpled-up cover. The resident also was observed trying to manipulate the wheelchair locks. At about 20 minutes into the video, the resident threw the crumpled cover onto the floor. About 21 minutes into the video, a newly arrived person picked up the crumpled cover and handed it back to the resident, who was playing with his urinary catheter tubing at that time. At approximately 22 minutes, the resident was observed either blowing his nose and or wiping his face with the crumpled-up paper cover, that had just been on the floor. At 27 minutes into the video, Resident #2 was observed holding the urinary catheter bag and then dropped in onto the left footrest of his wheelchair, as the resident's left foot was between the two footrests. About 45 minutes into the video, Resident #2 was wheeled out of the cardiologist's office by two men, neither of which were the man who dropped him off originally and wheeled out of the office. During that video, 42 people were noted to enter the cardiology office through the door next to Resident #2.Review of additional documents provided by the cardiology office revealed as per a call log, their staff attempted to call the facility 13 times on 10/03/25 between 10:24 AM and 11:30 AM. The cardiology office also provided a written voice message from the family member dated 10/03/25 at 2:25 PM, that apologized for not being available for the appointment but, I was not aware that he had a doctor's appointment today because the facility does not communicate well with me.During an interview on 10/22/25 at 12:59 PM, when asked the process for residents with physician appointments, Staff B, Transportation Driver, explained the receptionist for the memory care unit sets up all the transportation and puts the paperwork in a binder at the receptionist's desk in the facility. The driver stated he checks the binder daily and arranges his day. When asked if staff accompany the residents, the driver stated, very occasionally. The driver volunteered he feels staff are needed as a resident may try to unbuckle or need some type of help. The driver is unsure who would make the decision for staff to accompany a resident.During a phone interview on 10/22/25 at 1:44 PM, when asked about the process for resident appointments, Staff C, Licensed Practical Nurse (LPN) and direct care nurse for Resident #2 on 10/03/25, explained there were numerous ways she was made aware of appointments. The LPN stated she was informed by the resident and or family, the home board for communication, or the banner on the electronic record. The LPN explained she would let the Certified Nursing Assistant (CNA) know what time they needed to have the resident ready and would prepare and send paperwork with the resident, to include a face sheet and medication record. When asked if a resident was accompanied by staff to the appointments, the LPN stated they do not, but if there was a need it would be communicated to the Unit Manager. The LPN volunteered she had not had that situation. When asked if she recalled Resident #2, the LPN stated she did and that the resident was not alert and oriented, was very forgetful, and would not be appropriate to go to an appointment alone. When asked if she recalled the appointment for Resident #2 on 10/03/25, the LPN stated she had, and had communicated previously with the resident's daughter about the need to go with the resident for appointments and the daughter had been doing so. The LPN stated the resident had a lot of appointments and she assumed the daughter would be there as the Unit Manager and schedulers usually coordinate that. The LPN stated, I guess that one's on me . I just thought she would be there but did not check with her about that appointment. When asked how Resident #2 was dressed for the appointment, the LPN stated he had no clothing at the facility, so<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | she made sure the CNAs double-gowned him to make sure he was covered front and back. When asked if there was any facility practice of supplying residents who have no clothing with clothing the LPN stated she was not aware of anything. During an interview on 10/22/25 at 2:10 PM, when asked if she was aware Resident #2 was sent out to a physician appointment alone and in a hospital gown, the Social Services Director (SSD) stated, Oh no . we don't do that . it is just common sense.During an interview on 10/22/25 at 3:07 PM, the Assistant Director of Nursing (ADON) explained she had been at the facility about three weeks and had known about the appointment issues with Resident #2 on 10/03/25. When asked if she was aware of the way in which Resident #2 was dressed at the appointment, the ADON stated she was made aware after he had already left the facility and staff informed her they had not wanted him to miss the appointment. The ADON stated there was a lost and found with clothing that could have been used for Resident #2. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and record review, the facility failed to coordinate care to ensure 2 of 3 sampled cognitively impaired residents, were appropriately accompanied and or able to be seen at scheduled appointments. Resident #2 had a scheduled new patient cardiology appointment and the facility failed to inform the resident representative of the appointment, failed to ensure needed pre-authorization as per his insurance, failed to send the resident appropriately clothed to ensure comfort, and failed to accompany the resident to the appointment. Resident #4, who was also cognitively impaired, was sent unaccompanied to a medical appointment at the Veteran Affairs (VA) Medical Center.The findings included:1) Review of the record revealed Resident #2 was admitted to the facility on [DATE] with a diagnosis of cognitive communication deficit. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 3, on a 0 to 15 scale, indicating severe cognitive impairment. This same MDS also documented the resident had bilateral lower extremity impairment, needed the total assistance from staff for transfers, toileting, and lower body needs, while needing substantial to maximum assistance from staff for upper body needs.<br><br>Review of the Transportation Appointment log for 10/03/25 documented Resident #2 had an appointment at 10:45 AM, with the name of the cardiologist and address of the cardiology office listed on the log. This log documented the resident's insurance was providing the transportation with a pick-up time of 9 to 9:30 AM.<br><br>Review of the record lacked any order or progress note related to the cardiology appointment. Review of the resident's care plans revealed as of 08/27/25 the resident had a potential for ADL (activities of daily living) self-care deficit and may need dependent assistance for care; the resident had an indwelling urinary catheter; had an altered cardiovascular status; and was at risk for falls with a history of falls.<br><br>During a phone interview on 10/22/25 at 10:33 AM, the cardiology office Practice Manager explained that Resident #2 had a new patient cardiology appointment scheduled for 10/03/25. The Practice Manager explained that when an appointment was made with a resident who resides in a facility, especially a cognitively impaired resident, their office staff explains the paperwork that is needed and that the resident must be accompanied by facility staff or a family member to assist with the resident and obtain needed paperwork. The Practice Manager explained Resident #2 was dropped off by a driver, who handed the receptionist paperwork, and started to leave. The driver was asked if anyone was accompanying the resident, and the driver stated he was just told to drop off the resident and left. The Practice Manager explained their receptionist was unable to reach anyone at the facility, and further explained she herself had called multiple times, speaking with the receptionist of the facility, who had no knowledge of the appointment, and that she was put through to staff on numerous calls but was never able to speak with any nursing staff. The Practice Manager stated she left messages requesting the facility to call back, which never happened. The Practice Manager explained that their office staff also reached out to the three family members listed on the resident's face sheet but did not get a response until after the resident left. A voice message was left by a family member of Resident #2, who apologized and stated she was unaware of the appointment.<br><br>During the continued phone interview on 10/22/25 at 10:33 AM, when asked to describe what she saw with Resident #2, the Practice Manager stated she saved the video of the main waiting area for that date and pulled it up while on the phone. The Practice Manager described Resident #2 arriving at the<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | cardiologist's office, wearing two hospital gowns and hospital socks, sitting in a wheelchair. The Practice Manager stated the resident was wearing oxygen and was constantly playing with his gown, exposing his adult brief. She noted the tubing of an indwelling urinary catheter as well. The Practice Manager stated her staff provided him with a paper cover, used for patients during diagnostic testing, but the resident crumpled it up and offered it to another resident in the waiting area. The Practice Manager stated the office thermostat was maintained at 72 degrees F.<br><br>The Practice Manager concluded by explaining Resident #2 was never seen by the physician and was eventually picked up and taken back to the facility. She explained the information provided by the facility did not even have the correct transportation company listed, as she had called the listed company and they had no knowledge of the resident.<br><br>Review of the 45-minute-long video of the main waiting area, provided by the cardiology office, revealed the following: Resident #2 was wheeled into the office and placed in front of the receptionist's window. The man who pushed him into the office, dropped off some papers, started to leave when he was apparently called back, motioned that he dropped off the resident, and left. There were five other patients in the waiting room at that time. Resident #2 was wearing two short-sleeved hospital gowns and hospital type socks. Resident #2 was left in front of the receptionist's window in his wheelchair for a couple of minutes. When two additional patients arrived to check in, an office staff member moved the resident out of the way of the receptionist's window and placed him near the chairs located near the entrance door. Resident #2 was observed continuously manipulating his hospital gown exposing his legs and adult brief. At approximately 5 minutes into the video, office staff provided a paper-type cover, spread it out, and covered the lap of Resident #2. The resident immediately crumbled it up and offered it to another patient sitting next to him. Throughout the 45-minute video, Resident #2 continued to play with his gown and the crumpled-up cover. The resident also was observed trying to manipulate the wheelchair locks. At about 20 minutes into the video, the resident threw the crumpled cover onto the floor. About 21 minutes into the video, a newly arrived person picked up the crumpled cover and handed it back to the resident, who was playing with his urinary catheter tubing at that time. At approximately 22 minutes, the resident was observed either blowing his nose and or wiping his face with the crumpled-up paper cover, that had just been on the floor. At 27 minutes into the video, Resident #2 was observed holding the urinary catheter bag and then dropped in onto the left footrest of his wheelchair, as the resident's left foot was between the two footrests. About 45 minutes into the video, Resident #2 was wheeled out of the cardiologist's office by two men, neither of which were the man who dropped him off originally and wheeled out of the office.<br><br>Review of a letter dated 10/03/25 from the cardiology office to the facility documented in part that Resident #2 was not seen for his scheduled new appointment due to several critical issues including the failure to obtain prior authorization as per his insurance requirements; lack of accompaniment by a nurse, staff member, or family representation which led to the inability to complete required intake forms; and no valid form of identification. This letter also documented multiple efforts by both the front desk staff and office manager that were made and they were unable to reach the facility's head nurse, manager, or any of the three listed emergency contacts. This letter documented, For the safety and care of all patients, any patient who cannot advocate for themselves must be accompanied by a family member or facility staff (e.g., a nurse) during all medical appointments. This letter was signed by the cardiology office Practice Manager.<br><br>Review of additional documents provided by the cardiology office revealed as per a call log, their staff attempted to call the facility 13 times on 10/03/25 between 10:24 AM and 11:30 AM. The cardiology<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | office also provided a written voice message from the family member dated 10/03/25 at 2:25 PM, that apologized for not being available for the appointment but, I was not aware that he had a doctor's appointment today because the facility does not communicate well with me.<br><br>During an interview on 10/22/25 at 12:40 PM, when asked the process for residents with physician appointments, Staff A, receptionist, stated the nurse's make the appointments and the receptionist from their memory care unit schedules all transportation services for the campus. Staff A explained if the resident had private insurance, they would use whatever the insurance provided, but if they don't have insurance the facility would provide transportation with their vehicle and Staff B, Transportation Driver.<br><br>During an interview on 10/22/25 at 12:59 PM, when asked the process for residents with physician appointments, Staff B, Transportation Driver, explained the receptionist for the memory care unit sets up all the transportation and puts the paperwork in a binder at the receptionist's desk in the facility. The driver stated he checks the binder daily and arranges his day. When asked if staff accompany the residents, the driver stated, very occasionally. The driver volunteered he feels staff are needed as a resident may try to unbuckle or need some type of help. The driver is unsure who would make the decision for staff to accompany a resident. When asked if he transported Resident #2 to the cardiologist appointment on 10/03/25, the driver stated he did not recall the name or face and did not believe he transported that resident.<br><br>During a phone interview on 10/22/25 at 1:44 PM, when asked about the process for resident appointments, Staff C, Licensed Practical Nurse (LPN) and direct care nurse for Resident #2 on 10/03/25, explained there were numerous ways she was made aware of appointments. The LPN stated she was informed by the resident and or family, the home board for communication, or the banner on the electronic record. The LPN explained she would let the Certified Nursing Assistant (CNA) know what time they needed to have the resident ready and would prepare and send paperwork with the resident, to include a face sheet and medication record. When asked if a resident was accompanied by staff to the appointments, the LPN stated they do not, but if there was a need it would be communicated to the Unit Manager. The LPN volunteered she had not had that situation. When asked if she recalled Resident #2, the LPN stated she did and that the resident was not alert and oriented, was very forgetful, and would not be appropriate to go to an appointment alone. When asked if she recalled the appointment for Resident #2 on 10/03/25, the LPN stated she had and had communicated previously with the resident's daughter about the need to go with the resident for appointments and the daughter had been doing so. The LPN stated the resident had a lot of appointments and she assumed the daughter would be there as the Unit Manager and schedulers usually coordinate that. The LPN stated, I guess that one's on me . I just thought she would be there but did not check with her about that appointment. When asked how Resident #2 was dressed for the appointment, the LPN stated he had no clothing at the facility, so she made sure the CNAs double-gowned him to make sure he was covered. When asked if there was any facility practice of supplying residents who have no clothing with clothing the LPN stated she was not aware of anything.<br><br>During an interview on 10/22/25 at 3:07 PM, the Assistant Director of Nursing (ADON) explained she had been at the facility about three weeks and had known about the appointment issues with Resident #2 on 10/03/25. The ADON stated they spoke with staff involved who explained a process they thought was working, so the ADON started monitoring the appointments and identified additional resident appointment concerns. The ADON stated they put a new process in place just yesterday, 10/21/25. When asked the criteria for determining if a resident was able to go to an appointment<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | independently, the ADON stated they would go primarily by the resident's most current BIMS score. The ADON further stated a resident would need a BIMS of 12 or 13 and higher to be considered safe to go to an appointment independently. When asked if a resident with a BIMS of 9 could independently go to an appointment, the ADON stated, No, that would not be appropriate.<br><br>2) A record review revealed that Resident #4 was admitted to the facility on [DATE]. His diagnoses included Unspecified Sequelae of Cerebral Infarction, Metabolic Encephalopathy, Mild Cognitive Impairment of Uncertain or Unknown Etiology, Cerebral Ischemia, Dysphagia, Pharyngoesophageal Phase (difficulty swallowing), Unsteadiness on Feet, and Chronic Post Traumatic Stress Disorder. Resident #4's Brief Interview for Mental Status (BIMS) score, per Minimum Data Set (MDS) assessment dated [DATE], was 9. This indicated that Resident #4 had moderate cognitive impairment.<br><br>A record review of the Resident #4's electronic medical record revealed a progress note entered on 10/22/25 at 8:23 am that documented Resident LOA for Apt VA follow up colonoscopy procedure. LOA stands for leave of absence. Apt VA stands for Appointment Veterans Affairs.<br><br>During an interview on 10/22/25 at 9:00 am, Resident #4 was sitting alone outside the front door of the facility. He was wearing a Veteran's hat. He said he was waiting to be picked up to go to a follow-up exam. When he was asked how Veterans usually inquire about Veterans Affairs Benefits, Resident #4 said that there were monthly meetings held in the Senior Center. He explained that the person who ran the meetings was always helpful when he had any questions. A few minutes later, a CNA exited the facility. While she passed Resident #4, she told him she left his breakfast in his room. They exchanged some dialogue. Then, the CNA walked towards the parking lot and Resident #4 remained waiting in his wheelchair in front of the entrance to the facility. There were no facility employees outside with him after the CNA left.<br><br>During an observation on 10/22/25 at approximately 10:30 am, Resident #4 was picked up for his appointment. The driver helped him get into the van.<br><br>During interview with Resident #4 in his room on 10/22/25 at 4:58 pm, after he returned from his appointment, he explained that he was driven to the Veterans Affairs (VA) Medical Center by transportation provided by the VA. When asked the name of the transport company he said it was called: Special Modes for transportation. Resident #4 said They dropped me off. When asked how he got back to the facility, he explained that after appointments, there's a waiting spot that everyone knows, and I went to that spot, and they picked me up. When Resident #4 was asked if there was someone from the facility with him during the appointment, or a member of his family with him when he was there, he said No one accompanied me to the appointment. He added that his family did not live in this state. |